UTILIZATION MANAGEMENT CONSULTATION REPORT TO THE WEST VIRGINIA COURT MONITOR

Submitted by

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TABLE OF CONTENTS

UTILIZATION MANAGEMENT CONSULTATION REPORT TO THE WEST VIRGINIA COURT MONITOR

EXECUTIVE SUMMARY

INTRODUCTION

The state of West Virginia has contracted with Clinical Services Management, PC (CSM) to perform a "Utilization Management Review" of its Guidelines that govern reimbursement for community behavioral health services in the context of helping the parties in the *E.H., et al. v. Khan Matin, et al.* (Hartley) case. CSM is a behavioral healthcare consulting and management organization with extensive experience in systems analysis and strategic planning for state mental health and developmental disabilities authorities and providers of hospital and community-based behavioral healthcare services. CSM utilized six senior consultants to complete this project.

METHODOLOGY

The CSM team performed a series of reviews intended to gain insight into West Virginia's Utilization Management Guidelines. An assessment was completed to compare the WV Guidelines against those employed by other states and to review alignment of the guidelines with federal and state Medicaid law and regulations. In addition, three site visits were performed in WV in order to gain input from a variety of important stakeholders, including state and APS officials, a number of behavioral health provider organizations, consumers, families and advocates. The purpose of this multifaceted UM review was to assess whether the guidelines and approach to governance employed by WV and its Administrative Services Organization, APS Healthcare, supported the development and provision of effective and cost efficient community mental health and addictions services.

HISTORY

Based upon the written reports and verbal history provided to CSM during the UM Review, West Virginia once had a reasonably robust and progressive community system of behavioral healthcare. As community services expanded and evolved, the expense of funding the system of care increased. West Virginia, like many other states, developed strategies to shift the burden of these growing costs toward Medicaid funding. Recommendations made by an external consulting organization suggested that WV should take advantage of a very favorable Medicaid match. Services formerly funded exclusively by state dollars were now billed to Medicaid. In this manner the state scaled back its human services budget while further expanding services. The ensuing rapid expansion of Medicaid billing led directly to an audit by the federal government (CMS, formerly HCFA). Upon review many of these practices were found to be unallowable.

As a result, the state and the Comprehensive Mental Health Centers had to pay back millions of dollars, combined with penalties.

This event proved to be a traumatic turning point. The "Disallowance" profoundly impacted the evolution of the community system of care. As a victim of assault may become, agoraphobic or isolative, systems can react to a crisis by adopting an increasingly cautious and conservative approach. Following the disallowance, oversight of the West Virginia mental health system became more restrictive and inflexible. Distrust and frustration created deep divisions between the community providers and state behavioral healthcare leadership. Medicaid billing practices shifted from aggressive and expanding to rigidly conservative. As a result, Medicaid revenue dropped precipitously. The state dollars, which had subsidized the system before the shift to Medicaid, were not replaced. In remediating the disallowance (in a step reportedly required by HCFA) a managed care organization (APS), was contracted to serve as an Administrative Service Organization (ASO). As one of its priorities, APS implemented systems and processes to ensure that providers were strictly compliant with the new Medicaid Plan.

The disallowance and its sequelae began a process of disintegration in the community system of care. Previously, the community reportedly offered a wide variety of residential services, a full range of treatment options, and (as a result) a low census in the state hospital. Following the disallowance the system rather quickly declined to the present inadequate state of service. As providers struggled to maintain solvency, many community-based services and options (especially for those with severe and persistent mental illness and co-occurring substance abuse problems) were closed or severely scaled back.

In the past decade the state psychiatric hospitals have experienced significant overcrowding. As a result of the breakdown of the community safety net of services, involuntary commitments of patients increased substantially after the disallowance. An expanding number of forensic patients have been committed to state facilities and a young severely ill population of individuals with co-occurring mental illness and substance abuse disorders has emerged. A new category of inpatient treatment, the "diversion hospital" was developed to ensure access to inpatient care despite the high census in the state hospitals. These diversion units are highly reimbursed by state dollars. The cost of this service has nearly doubled (from $6.9M to $12.5M) since 2008.[1] Reportedly, an average of more than one hundred patients per day are housed in diversion units. Contrary to progressive trends throughout the country, West Virginia's utilization of restrictive inpatient settings has increased.

In 2008, Judge Louis H. Bloom issued the Agreed Order in E.H., et al. v Khan Matin, et al. which mandated the implementation of a three-year, thirty million dollar plan to improve various components of the services in the state. The Order also dictated increases in some of the reimbursement levels for various Medicaid codes, as well as requiring changes in the manner in which some of these codes were interpreted. The Court directed the state to maximize availability of clinic and rehabilitation services under federal regulations. Subsequently, the growing crisis in the mental health system led directly to the reinstitution of the Court Monitor to oversee and report on the progress of required improvements in the system. In this context, the Monitor contracted with CSM to perform this review of Medicaid utilization management and its

[1] Much of the state funds directed to diversion hospitals are expenditures not eligible for a Medicaid match.

impact on the behavioral health system of care.

MEDICAID GUIDELINES REVIEW

As a result of the issues surrounding compliance, CSM reviewed federal and state statutes related to Medicaid to identify any opportunities for flexibility in altering the guidelines in order to increase access to services. At the request of BMS, West Virginia's Medicaid State Plan and relevant BMS Medicaid manuals were also reviewed against the ASO guidelines to identify any areas of inconsistency. In addition, CSM reviewed UM Medicaid programs guidelines used in Nebraska, Iowa and Texas and compared them with the approach employed in West Virginia. A methodology was developed for selection of comparison programs based on research, our own experience with best practices in other states, and input from BMS.

General Findings

- All three state comparison programs provide a broader continuum of community-based rehabilitation services than West Virginia.
- The UM guidelines of the three comparison states stress individual consumer needs and strengths in the guidelines to a greater extent than do West Virginia's guidelines.
- With the exception of UM guidelines for ACT, West Virginia's guidelines do not include a focus on recovery principles.
- Compared to other states reviewed, West Virginia's UM guidelines place more emphasis on compliance rather than on how services can assist consumers to live meaningful lives in the community.
    - West Virginia's guidelines include language that services are designed to improve or preserve a member's level of functioning; however, in practice the primary emphasis is on improvement.
    - Active treatment is needed for some individuals to preserve their level of functioning and prevent the need for intensive, more costly levels of care.
- The authorization decisions of APS do not routinely take into consideration both the individual's immediate treatment needs, as well as long-term strengths, needs, choices, and goals.
- In practice, these authorization decisions are heavily focused on demonstrated improvement in functioning rather than acknowledgement that a service may be required to maintain level of functioning, increase community tenure, and reduce the need for more restrictive levels of care.

Recommendations

CSM's review of medical necessity definitions, and UM guidelines resulted in the recommendations below, which if implemented, will in part support recipients in having greater access to recovery-oriented services and promote community tenure. These recommendations primarily address guidelines in place for current services. Another critical gap in the West Virginia system is the limited service array compared to other states. The state has made some progress in this area with the revision of guidelines and processes for ACT, which is an evidence-based practice and will provide a valuable service for consumers who have a serious mental illness. However, as in other states such as Nebraska, the service will likely have limited use in rural areas due to limited resources to meet the model's staffing and administrative requirements. Well-planned development of additional services will be another important step in increasing access to services.

Recommendations include:

- Develop guidelines similar to the Nebraska ASO and Iowa Plan for the medical necessity of rehabilitation services to fully incorporate psychosocial rehabilitation and recovery principles, which are aligned with national policy promoting community-based rather than institutional services. Include knowledgeable West Virginia providers practicing or teaching in the field in guideline development.

- Evaluate the feasibility and sustainability of developing a broader service array, such as mental health home health, mobile crisis, medication training and support services, respite, psychosocial rehabilitation, 23 hour crisis observation, evaluation, holding and stabilization, psychiatric residential rehabilitation, and customer assistance program. Service enhancement is especially important in rural areas where ACT will likely be of limited use. Since ACT is an evidence-based practice with very specific requirements and fidelity measures, rural providers often do not have access to the required staffing resources and may not be able to meet caseload requirements.

    - Ensure that these innovations will address the needs of a changing population of younger individuals with co-occurring mental health and substance abuse problems.

- Incorporate the Substance Abuse and Mental Health Services Administration (SAMHSA) nationally recognized recovery principles into the UM guidelines and authorization process.[2]

- Revise UM guidelines to remove specific timeframes for expected improvement (particularly for day treatment and skills training and development). The revisions should include a focus on individual strengths and needs, recovery, and community tenure.

[2] http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf

- Modify the UM guidelines for ACT to make them consistent with the State Plan document. Remove the requirement for some targeted populations to be authorized for admission on a case-by-case basis.

- Modify the definition and requirements for frequency of face-to-face contact for targeted case management. Embed advocacy in all elements of the service rather than defining it as a separate service component. Reduce the requirement for frequency of face-to-face contact and require more frequent face-to-face contact based on individual needs.

- Evaluate the need for expanded criteria for personal care services specifically for individuals who have needs for these services as a result of a behavioral health disorder.

- Establish a process for APS to track and report renegotiations and trend over time in order to identify any inappropriate reductions/restrictions related to service authorization.

- Evaluate and resolve discrepancies noted in the BMS manuals and UM guidelines.

- Define roles and responsibilities for APS and provider coordination of care with primary care, community agencies and other service providers in order to avoid duplication in service provisions and conflicting treatment and service plans.

REVIEW OF STAKEHOLDER FEEDBACK

In order to clarify and quantify the information and impressions provided by various participants involved in the system of behavioral healthcare for adults in WV, CSM performed a multi-faceted review process. The team performed in-person and telephonic interviews with various providers, brief tours of provider service settings, visits to the two state hospitals and interviews with their staff, visits to a small sample of diversionary hospitals, interviews with consumers/family members, and the use of a web-based survey completed by the Comprehensives. In addition, CSM reviewed a number of salient reports authored by various consultants, commissions, providers, and other sources.

Although some might maintain that the findings and observations identified during this part of the project are "opinion" and therefore somewhat subjective, they contain significant information. The feedback provides us with insight into the experiences of providers and consumers with whom we spoke who are attempting to deal with the realities of a deteriorating mental health system of care. The majority of those interviewed and/or those respondents to the survey agree that the current system of care is extremely weak and void of sufficient resources to effectively meet the needs of consumers. In addition, many of their concerns and specific criticisms of the existing Medicaid authorization and reimbursement process were validated during CSM's review and comparison of the state's UM Guidelines.

General Findings

- All stakeholders agreed that the absence of a full continuum of care was a major issue facing both providers and consumers alike
- The inability to consistently obtain authorization for certain approved services including day-treatment and targeted case management has also effectively minimized the care available to patients
- Documentation requirements for certain service codes is perceived as being unrealistic or simply cost prohibitive while the medical necessity guidelines for other services are too rigidly interpreted
- Over census issues at the state hospitals can, at least in part, be traced back to the lack of a full continuum of care in the community
- With few exceptions, the Comprehensives are facing significant financial challenges
- The MCO model of care being proposed by West Virginia for the integration of primary and behavioral healthcare does not align with federally supported current research regarding individuals with serious and persistent mental illnesses and/or addictions. Those with more serious and persistent problems have been found to benefit from an integration where primary care is provided within the behavioral healthcare organization.
- The existing Medicaid reimbursement system does not adequately account for the demographic and geographic diversity of the state
- The provider system has a historically-based distrust in the state leadership's ability to successfully facilitate necessary changes to the system. Several providers expressed hope that the relatively new leaders, as well as ongoing improvements in staffing levels at various government agencies, will allow for improvements in this area
- The absence of a comprehensive state-wide plan for behavioral health has resulted in a system of care that is perceived by the majority of stakeholders as fragmented, ineffective, and incapable of meeting the needs of the most fragile elements of society.

Recommendations

The behavioral healthcare system in West Virginia is experiencing a prolonged crisis. Major providers are struggling financially while consumers, especially those in rural areas, are often unable to access a sufficient level of care to ensure their continued stability in the community. In the past decade new patient populations have emerged to further stretch the state's limited resources. State hospitals have been charged by the courts with the responsibility to manage a substantial cohort of forensic patients who require long-term institutionalization. There is also an expanding group of younger patients with significant co-occurring substance abuse and mental health disorders. These dually diagnosed individuals are characteristically treatment resistant, require repeated inpatient stays and typically have little or no insurance or other benefits. Management of the primary funding mechanism (Medicaid) unnecessarily limits access to certain core services while other key service components (i.e., residential, transportation and

medication) are not adequately subsidized by state dollars. The relationship between state leadership and the provider base is strained and largely non-productive. In summary, the majority of stakeholders are frustrated and pessimistic about the system's lack of clear direction and capacity to improve going forward.

The need for the state to rapidly develop and formalize a comprehensive plan for behavioral health cannot be stressed enough. In lieu of one, the system will likely continue to be fragmented and reactive instead of proactively dealing with the historic causes of failure. Key elements of the plan should include:

- Provision of a full continuum of care that adequately accounts for existing barriers created by geographic, demographic and regional differences
- Adoption of Wellness and Recovery Principles along with evidence-based practice models
- Development of a comprehensive workforce development strategy to ensure that there are sufficient competent and knowledge personnel to staff these advanced services.
- Consider the development of a specialized facility for the management of forensic patients
- Inclusion of all stakeholders in both design and implementation
- Development of multi-faceted and sustainable funding strategies that appropriately maximizes the utilization of Medicaid funds, Federal Block Grants, dedicated state dollars and other funding sources
- Support for and continuing refinement of integration efforts between primary care and behavioral healthcare aligned with existing Federal initiatives, especially for those with severe and persistent mental health and co-occurring substance abuse problems

Specific areas for consideration during the plan development should include:

- Use of the 1915i Medicaid Plan Amendment option to provide specialized services and delivery options (e.g., intensive case management services and CSU programs in less populated areas)[3] [4]
- Improving the capability of all providers of CSU services to facilitate the treatment of a more acute patient population and to provide an alternative to the current diversion hospital program.
  - Explore the use and/or development of other community-based services to keep individuals out of hospital, such as respite, ambulatory detox, mobile crisis, etc.
- Explore the development of "Health Homes" designed to improve primary care and mental health service integration while taking advantage of the two-year 90% federal match.[5]
- Improve communication and participation of stakeholders statewide through the exploration of regional and teleconferencing methods

[3] http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Medicaid/The_Home_and_Community_Based_Option_final.pdf
[4] http://www.bazelon.org/LinkClick.aspx?fileticket=XI9rDQNLeRc%3d&tabid=242
[5] http://www.samhsa.gov/samhsaNewsletter/Volume_18_Number_5/SeptemberOctober2010.pdf

- Ensure that the specialized service needs of the "aging-in" population are adequately accounting for in any plan design
- Strengthen the role of Care Coordinators in the system
- Consider the use of "individualized" state grants and/or other creative funding mechanisms to support the discharge of difficult to place individuals from the state hospital.[6]

CONCLUSION

In recent years there have been many advances in approaches to mental health services on a national level. For example, in its report "*Achieving the Promise: Transforming Mental Health Care in America*", The President's New Freedom Commission on Mental Health formed by President George W. Bush identified the need to reshape the nation's mental health system. Among other findings and recommendations, the commission identified two principles for successful transformation of the system:

First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers not oriented to the requirements of bureaucracies.
Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.[7]

The commission also specified that "More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs. Treatment and services that are based on proven effectiveness and consumer preference — not just on tradition or outmoded regulations — must be the basis for reimbursements."[8]

In 2006, the Substance Abuse and Mental Health Services Administrative released its national consensus statement on the ten fundamental components of mental health recovery which includes[9]:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer support
- Respect

[6] CSM understands that proposals similar to this have recently been made.
[7] "*Achieving the Promise: Transforming Mental Health Care in America*", The President's New Freedom Commission on Mental Health, page 11, July 22, 2003.
[8] "*Achieving the Promise: Transforming Mental Health Care in America*", The President's New Freedom Commission on Mental Health, pages 9, 12, July 22, 2003.
[9] http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf

- Personal Responsibility
- Hope

These principles are not just words on paper. To truly embrace them requires a fundamental shift in how mental health services are configured and delivered. No longer is treatment something that is imposed on consumers by professionals and administrators, but a collaborative process that puts the consumer at the very center of a meaningful planning and recovery process.

In addition, in 2009, President Obama announced the "Year of Community Living" to mark the 10th anniversary of the *Olmstead v. L.C.* decision, in which the U.S. Supreme Court affirmed a State's obligation to serve individuals in the most integrated setting appropriate to their needs. In the *Olmstead* decision, the Court held that the unjustified institutional isolation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act.[10] To support this initiative, the Department of Health and Human Services (HHS) announced the Community Living Initiative. As part of the initiative, HHS is working with several Federal agencies, including the Centers for Medicare & Medicaid Services (CMS), to implement solutions that address barriers to community living for individuals with disabilities (including mental illness) and older Americans.

CMS supports the transformation in other ways as well. States have considerable latitude in shaping their Medicaid programs. While each state's Medicaid program must meet mandatory Federal requirements, including covering essential health service, and serving core eligibility groups, Federal law and regulations give States many options to customize the design of their service delivery system. In addition, CMS also provides the flexibility to address the unique needs of patients and families through various waivers and demonstration projects. CMS encourages this approach and offers technical assistance to states regarding the design and operation of their Medicaid programs.

In direct contradiction to these mandates and initiatives, West Virginia's behavioral health system is heavily oriented toward regulatory compliance, promotes involuntary inpatient confinement, focuses on managing discreet "episodes of care" and symptom management rather than individualized treatment and supports that promote recovery and community tenure for persons with mental illness. A more preventative or proactive approach is needed. Utilization management (UM) guidelines are just one component of the system that contributes to the lack of comprehensive services that support recovery and community living. Compared to other states reviewed the UM guidelines appear more focused on why a person is ineligible to receive services rather than how services that assist consumers to live in the community and lead meaningful lives can be tailored to individual needs. While regulatory compliance is important and necessary, it should not be the primary focus of UM. Effective UM programs promote access to appropriate services based on an individual's needs and strengths and result in optimal outcomes for consumers, while at the same time managing utilization and costs. This means that authorization decisions take into consideration not only an individual's immediate treatment needs, but long-term strengths, needs, choices and goals as well. In practice, service authorizations may be for shorter or longer time periods and for different service mixes

[10] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

depending upon where a consumer is at in his or her recovery process. In other words, persons with similar diagnoses and symptoms may require different services due to their unique circumstances. While West Virginia's guidelines for rehabilitation services do include service descriptions that incorporate "interventions which are intended to provide support to the member in order to maintain or enhance levels of functioning"[11], in practice authorizations are heavily focused on demonstrated improvement in functioning rather than acknowledgement that a service may be required to maintain level of functioning, increase community tenure, and reduce the need for more restrictive levels of care. If justified through documentation that a consumer is likely to deteriorate without continued interventions the service should be authorized.

Another critical gap in the West Virginia system is limited service capacity compared to other states. The state has made some progress in this area with the revision of guidelines and processes for assertive community treatment, which is an evidence-based practice and will provide a valuable service for consumers who have a serious mental illness. However, as in other states such as Nebraska, the service will likely have limited use in rural areas due to limited resources to meet the model's staffing and administrative requirements. More importantly, there seems to be a lack of a comprehensive plan and philosophy for advancing West Virginia's mental health delivery system. The long standing objective has been to avoid disallowances. Although this is important, it should not be the main objective of the system. Additionally, "plugging holes" in the system through development of a service here or there, revising guidelines, or providing one time sources of funding is ineffective in providing a comprehensive continuum of care that is sustainable.

Other states have made significant strides in system transformation. For example, Iowa has been successful in increasing access to services, reducing inpatient lengths of stay and expanding the array of available services for Medicaid recipients by developing recovery-driven services and UM guidelines, in a cost-effective manner.[12] The present weaknesses in the West Virginia system are the result of a decade of deficiencies in planning and vision. A comprehensive approach and plan for transformation is needed that encompasses all aspects of the system.

In conclusion, CSM began our process with the purpose of reviewing Medicaid utilization management and its impact on the West Virginia system of behavioral healthcare. As detailed in this report, our findings support the conclusion that the design and administration of the Medicaid mental health services plan has evolved to become unnecessarily limited and restrictive. In brief, despite recent progress, APS and the Medicaid system fall short of the direction given by Judge Louis H. Bloom in the Agreed Order to "maximize availability of those [clinic and rehabilitation] services within the federal regulations."[13] However, it should not be inferred that the shortcomings in Medicaid are the primary ***cause*** of the problems facing the community behavioral health system of care. Medicaid's limitations are more realistically an outgrowth or a symptom of the fundamental flaws inherent in the behavioral health system. In the past decade many states have adopted progressive approaches to supporting the emotional health and well-being of individuals living with serious and persistent mental illnesses and/or addictions. In those states, Medicaid performs the function for which it is best suited, being one

[11]Behavioral Health Rehabilitation Services Manual, West Virginia Bureau for Medical Services, page 15.
[12] http://www.dhs.state.ia.us/rts/Lib_Train/TCM/09-13-07/Magellan%20Overview.pdf
[13] Agreed Order, Paragraph 4, (b).

of the important reimbursement mechanisms which support the transformation of the system of care. Changes in Medicaid must be directed by an overarching planning process. West Virginia has a real opportunity for system transformation at a time when the Federal government is encouraging states to improve services and outcomes through innovation.

UTILIZATION MANAGEMENT CONSULTATION REPORT TO THE WEST VIRGINIA COURT MONITOR

I. INTRODUCTION

A. Salient Background of Project

The state of West Virginia has requested a "Utilization Management Review" of its Guidelines that govern reimbursement for community behavioral health services in the context of helping the parties in the *E.H., et al. v. Khan Matin, et al.* (Hartley) case. It has enumerated a series of objectives that are addressed throughout this report.

B. Description of Clinical Services Management, P.C.

Clinical Services Management, P.C. (CSM) is a behavioral healthcare consulting and management organization with extensive experience in contract management, strategic planning, and systems analysis for state mental health and developmental disabilities authorities and providers of hospital and community-based behavioral healthcare services. In the past thirty years, CSM, its principals, employees, and consultants have been responsible for developing, implementing, operating and evaluating behavioral health services throughout the continuum of care, including:

- Clinical and Provider Network design, implementation, and management of state and national behavioral health managed care programs
- Consultation to State HCBS programs for individuals needing Home and Community Based services for disabilities including mental health, developmental disabilities, traumatic brain injury, dual diagnoses, physical disability in adults from 18-65 as well as disabilities related to aging.
- Consultation and training for community providers of services to individuals with disabilities requiring mental health, substance abuse, developmental disabilities, aging and other health and support services to improve quality of care.
- Voluntary/Involuntary, Adult, Adolescent and Children Inpatient Units
- Psychiatric Emergency/Screening and Mobile Outreach Services
- Adult and Adolescent Residential Services
- Acute and Rehabilitative Partial Hospital Programs
- Traditional and Managed Care-Focused Outpatient Services
- Employee Assistance Programs
- State Licensing, Regulatory, and Accreditation Oversight and Consultation

In addition, members of the CSM Team possess specific expertise and experience with direct relevance to many of the key issues and decisions being considered by West Virginia.

CSM TEAM MEMBERS

The following list provides a brief overview of CSM staff and consultants who were involved in the project.

Team Member	Primary Roles	Related Experience
Peter Pastras, LCSW	Project Coordinator; field research and report development	Extensive healthcare administrative and operational experience; designed and implemented numerous assessment and strategic projects; lead consultant in numerous regional or statewide systems evaluation in the disabilities field
Charles Higgins, M.Div	Field research and report development	Extensive healthcare administrative and operational experience; designed and implemented numerous assessment and strategic projects; consultant in numerous regional or statewide systems evaluation in the disabilities field
Julie Bigelow, RN	Research Director: Perform comparison of UM guidelines, research federal and state laws and report development	Extensive experience in large national and statewide managed behavioral health care contracts including UM and provider networks.
Jeanne Wurmser, PhD	Survey design; data analysis and field research	Extensive healthcare administrative and operational experience; consultation to New Jersey Division of Developmental Disabilities & Division of Aging & Community Services on Home and Community-Based Services (HCBS) Waivers and CMS grant application/implementation
Craig Blum, PhD	Field Research Coordinator; survey design; and report development.	Former Joint Commission Surveyor, NJ Operations Manager for nation-wide managed care organization, and CSM Corporate Vice President Quality Improvement; Lead or research consultant in numerous regional or statewide systems evaluation in the disabilities field
Velvet Miller, RN, PhD	CMS expert and report development.	Extensive administrative and operational experience in healthcare; Former Deputy Commissioner in NJ Department of Human Services in charge of State Medicaid and welfare programs through the Division of Family Development and the Division of Medical Assistance and Health Services; and college/university professor.

CSM has led or participated in the performance of multiple program evaluations and needs assessments for entire states, as well as separate organizations providing services to individuals with mental illness, substance abuse, developmental disabilities and acquired brain injuries.

A more detailed explanation of the project and the identification of outcomes are outlined below.

II. PROJECT OUTLINE

A. Overview of Project

CSM's proposed approach consisted of the components listed below, with objectives (see Appendix 1 for the complete proposal):

- Phase I: Project Launch
- Phase II: Data Collection
  - **Objective 1**: *Review UM Guidelines that govern reimbursement for community behavioral health services (currently utilized by APS Healthcare) against other comparable guidelines for similar states to determine how the West Virginia guidelines can be tailored to satisfy their purpose more appropriately*.
  - **Objective 2**: *Review the guidelines against applicable federal and state Medicaid law and regulations to determine the flexibility and limits to altering the guidelines in order to increase access to services.*
  - **Objective 3**: *Gain input from a variety of behavioral health care providers who seek reimbursement under the guidelines to evaluate considerations of (i) too much discretion under the guidelines, which may have been used to arbitrarily increase denials through informal policy of the implementing authority (APS); (ii) guidelines that are too restrictive, thereby requiring denials for services that are appropriate and allowed under Medicaid law and regulations; and (iii) guidelines that are being misinterpreted or misapplied by the implementing authority*
  - **Objective 4**: *Interview advocates and consumers in order to identify services that are most lacking and necessary in their view; determine whether these same services are being denied under the guidelines; and make a recommendation as to how guidelines could be restructured to allow reimbursement for the proposed services.*
- Phase III: Data Analysis and Preliminary Review with West Virginia
- Phase IV: Report

- **Objective 5**: *Issue a comprehensive report with recommendations as to how the guidelines can be restructured under current legal constraints in order to increase access to services with attention to (i) eliminating discretion to deny appropriate services by clarifying the specific services that must be reimbursed and (ii) changing any unduly restrictive guidelines to allow reimbursement for all additional services (with particular attention to those services identified as lacking by providers, advocates, and consumers) that may be reimbursed under applicable state and federal law.*

III. THE CSM REPORT

A. Overview of Phase I and Phase II

CSM was initially contracted to complete this study in the spring 2010 (with a first contact in early December 2009), but a number of administrative issues in WV precluded this from happening. A few initial telephonic meetings were held during the first of the year, and a few additional ones were held prior to the official kick-off to allow CSM to ground itself in some of the basic historical and other issues confronting the system. Ultimately, the project kick-off meeting with the Court Monitor and the Project Management Team in Charleston, WV did not occur until September 28, 2010. As part of its process of review and fact-finding, CSM engaged in a number of activities, which will be reviewed in more depth below. Briefly, the kick-off meeting was followed by a number of in-person interviews with various provider groups, advocacy groups, consumer groups, various government oversight agencies, and APS during the same initial trip. In addition to the interviews, voluminous reports, papers, and other documents were obtained or sent soon after for review. This was followed by a number of telephonic follow-up calls to clarify issues, primarily with APS, BMS, and a few others to identify the three comparison states for review of UM and related guidelines and materials. These states were identified and materials were obtained for review. Another visit to the state occurred from October 28-29, 2010 to attend a Mental Health Planning Council meeting to meet with consumers and family members of consumers, as well as to review presentations being made by the proposed MCOs. Additionally, a day of travel to visit Bateman Hospital, a few diversionary hospitals, a non-Comprehensive agency, and other meetings were held. A final visit to the state was held from November 16-18, 2010 where a number of Comprehensives were visited, as well as Sharpe Hospital. Finally, telephonic interviews were completed with all the remaining Comprehensives that had not already been visited in person. A number of other telephonic follow-up calls were also made throughout September to December with organization staff and leaders to clarify issues or request additional information. Finally, a web-based survey was sent to all Comprehensives on December 3, 2010 and closed on January 7, 2011 to round out CSM's data collection. A total of 12 of 13 Comprehensives ultimately completed the survey. Throughout this time period the three comparison states were identified (see below for review of this), using input from various stakeholders in WV. Following this identification, information was obtained from WV and the other states to provide for comparisons on Medicaid requirements and practices between WV and the other states. Contact with CMS was initiated to ensure that the comparison states were deemed reasonable and in compliance with CMS regulations on their practices.

B. History of the System of Care

In order to gain perspective on the present status of the West Virginia community mental health system, CSM reviewed a number of written reports and conducted numerous interviews with individuals who possess an extensive knowledge of the relevant history of the system. From all accounts, West Virginia once had a reasonably robust and progressive community system of behavioral healthcare. In keeping with the national deinstitutionalization movement, West Virginia developed a community system while substantially reducing the number of state psychiatric beds achieving an average census in the State Hospital system of about 80-90 individuals (at any one time) by the mid-1990s. At that time, there were many group homes and other residential options, extensive day treatment programs, active case management, and a variety of other program elements were found across the state.

As community services expanded and evolved, the expense of managing the system of care increased. West Virginia, like many other states, developed strategies to shift the burden of these growing costs toward Medicaid funding. Recommendations made by an external consulting organization, Copeland Associates from Philadelphia, suggested that WV should take advantage of a very favorable Medicaid match. Services formerly funded by exclusively state dollars were directed to bill Medicaid. In this manner the state scaled back its human services budget while further expanding services. By report, the increase recommended by Copeland Associates was a limited and closely monitored process in its initial implementation. After the consulting group left, state leadership dramatically increased the transfer of what were largely state financed services to a primarily Medicaid-funded model (a process often referred to as the system being "Medicaided"). The particulars of this wholesale movement to Medicaid funding had various components that went well beyond what the initial consultants recommended. The ensuing rapid expansion of Medicaid billing led directly to an audit by the federal government (CMS, formerly HCFA). Upon review many of these practices were found to be unallowable. As a result, the state and the Comprehensive Mental Health Centers had to pay back millions of dollars, combined with penalties.

This event proved to be a traumatic turning point. The "Disallowance" profoundly impacted the evolution of the community system of care. As a victim of assault may become, agoraphobic or isolative, systems can react to a crisis by adopting an increasingly cautious and conservative approach. Following the disallowance, oversight of the West Virginia mental health system became more restrictive and inflexible. Distrust and frustration created deep divisions between the community providers and state behavioral healthcare leadership. Medicaid billing practices shifted from aggressive and expanding to rigidly conservative. As a result, Medicaid revenue dropped precipitously. The state dollars, which had subsidized the system before the shift to Medicaid, were not replaced. In remediating the disallowance (in a step reportedly required by HCFA), a managed care organization (APS) was contracted to serve as an Administrative Service Organization (ASO). As one of its priorities, APS implemented systems and processes to ensure that providers were strictly compliant with the new Medicaid Plan.

The disallowance and its sequelae began a process of disintegration in the community system of care. Previously, the community reportedly offered a wide variety of residential services, a full

range of treatment options, and (as a result) a low census in the state hospital. Following the disallowance the system rather quickly declined to the present inadequate state of service. As providers struggled to maintain solvency, many community-based services and options (especially for those with severe and persistent mental illness and co-occurring substance abuse problems) were closed or severely scaled back. In the past decade leading systems across the country aggressively developed alternatives to hospitalization and long-term institutionalization. The concepts of wellness and recovery and the introduction of evidence-based practices have supported the efforts of people with serious and persistent mental illness to live in the community with dignity. During that time period in West Virginia, the breakdown of the system resulted in increased census and significant overcrowding in the state hospitals. Involuntary commitments of patients increased substantially after the disallowance. A new category of inpatient treatment, the "diversion hospital" was developed to ensure access to inpatient care despite the high census in the state hospitals. These diversion units are highly reimbursed by state dollars (funds that are ineligible for a Medicaid match). In FY 2010, the state paid out over $12 million dollars in unmatched funds to diversion hospitals for those not eligible for Medicaid reimbursement.[14] The cost of this service has nearly doubled (from $6.9M to $12.5M) since 2008. Reportedly, an average of more than one hundred patients per day are housed in diversion units. Contrary to progressive trends throughout the country, West Virginia's utilization of restrictive inpatient settings has increased.

In addition to the narrowing of access to Medicaid reimbursement for clinic, rehabilitation and targeted case management services other changes to the Medicaid system were developed. A state plan amendment allowed for a program termed Mountain Health Choices. There was near universal agreement that the program was poorly conceived and designed with regard to those with chronic and persistent mental health problems. The program created significant financial and programmatic problems for providers and it was ultimately discontinued. A plan has been developed to further restructure the Medicaid model into a full Managed Care Organization (MCO) process. The plan calls for the designation of three MCOs to manage the oversight and integration of primary and behavioral healthcare. It was originally unveiled to begin sometime in late 2010, but has been delayed until sometime in 2011.

In 2008, Judge Louis H. Bloom issued the Agreed Order in E.H., et al. v Khan Matin, et al. which mandated the implementation of a three-year, thirty million dollar plan to improve various components of the services in the state. The Order also dictated increases in some of the reimbursement levels for various Medicaid codes, as well as requiring changes in the manner in which some of these codes were interpreted. The Court directed the state to maximize availability of clinic and rehabilitation services under federal regulations. Subsequently, the growing crisis in the mental health system led directly to the reinstitution of the Court Monitor to oversee and report on the progress of required improvements in the system. In this context, the Monitor contracted with CSM to perform a review of Medicaid utilization management and its impact on the behavioral health system of care.

[14] Additional dollars were generated by diversion hospital units for patients covered by Medicaid. CSM was unable to identify the total cost but it was clearly greater than the $12 million figure noted here.

IV. MEDICAID REGULATORY REVIEW AND COMPARISON OF WV WITH THREE OTHER STATES

West Virginia was in the process of bringing in the ASO prior to the disallowance. As mentioned above, when the disallowance occurred, the state included this additional component for system oversight in its corrective action plan to CMS. Both BMS and APS, in carrying out its contractual requirements have played a prominent role in shaping the service system. One of the roles of the ASO is to ensure compliance with the State Medicaid Plan, BMS rules, and federal regulations relating to utilization management (UM). Unfortunately, providers and other stakeholders report that utilization guidelines for clinic, behavioral health rehabilitation, and targeted case management services are too strictly applied. Along with burdensome administrative requirements it has become increasingly difficult to provide necessary services. As a result, Medicaid recipients are suffering, and providers are experiencing financial difficulties. In some cases, providers report that they simply "give up" and do not request authorization even though they believe the service is medically necessary and reimbursable under Medicaid.

In contrast to other public mental health programs across the country that are undergoing system transformation though development of recovery-oriented, community-based systems of care, West Virginia's focus on regulatory compliance has contributed to the significant gaps in services and restrictions in service provision for the services that remain.

As a result of the issues surrounding compliance, CSM reviewed federal and state statutes related to Medicaid to identify any opportunities for flexibility in altering the guidelines in order to increase access to services. At the request of BMS, West Virginia's Medicaid State Plan and relevant BMS Medicaid manuals were also reviewed against the ASO guidelines to identify any areas of inconsistency.

In addition, CSM reviewed UM guidelines used in three other Medicaid programs to gain further insight as to how West Virginia might improve its system. A methodology was developed for selection of comparison programs based on research, our own experience with best practices in other states, and input from BMS. These efforts, findings, and recommendations are described in the following sections.

A. Regulatory Review

Regulatory review was conducted on federal and state laws and regulations specifically related to UM, denial, and appeal requirements for Medicaid behavioral health clinic, rehabilitation, and targeted case management services. This included review of the Code of Federal Regulations (CFRs) with specific focus on relevant parts of CFR Title 42 and Chapters 9, 16, and 27 of the West Virginia Code. These reviews are summarized below.

1. Code of Federal Regulations Review

Part 440 (Services: General Provisions) includes service definitions (Subpart A §440.90, §440.130, §440.169) for clinic, rehabilitation, and targeted case management. It should be noted here that Medicaid policy revisions including proposed targeted case management and rehabilitation option rule changes are under consideration.

Subpart B (§440.230) requires the State to specify the amount, duration, and scope of each service it provides and that the amount, duration, and scope of each service be sufficient to reasonably achieve its purpose. It also allows the agency to place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures. §440.260 requires the State to have a description of methods and standards to assure that services are of high quality.

Part 456 (Utilization Control) prescribes requirements concerning control of utilization of all Medicaid services, including a statewide program of utilization control of all Medicaid services (§456.1). It does not mandate specific requirements for utilization control of clinic, behavioral health rehabilitation, or targeted case management, but mandates that the State Medicaid agency implement a plan for surveillance and utilization control that safeguards against unnecessary or inappropriate use of Medicaid services and excess payments, and assesses the quality of services. To promote the most effective and appropriate use of available services and facilities the Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services (§456.22). The program must also include a post-payment review process (§456.23).

Part 431 (State Organization and General Administration), Subpart E, §431.200-§431.250 delineates requirements for fair hearings for applicants and recipients, or his/her authorized representative. This Subpart outlines specifications for the provision of the hearing system, informing applicants and recipients, notices of action and determinations, when hearings are required, requests for hearings, service provision during the hearing process, parameters for conducting the hearing, and timeframes. §431.206 (a) requires the agency to issue and publicize its hearing procedures, and §431.221 (b) states that the agency may not limit or interfere with the applicant's or recipient's freedom to make a request for a hearing. It also provides for a hearing at the local level, with the right to appeal to a State agency.

Findings

Federal regulations generally provide overall guidance and the framework for UM requirements for clinic, behavioral health rehabilitation, and targeted case management services rather than mandating specific utilization requirements. States have considerable latitude in shaping their Medicaid programs. While each state's Medicaid program is subject to approval by CMS and must meet mandatory Federal requirements, including

covering essential health service, and serving core eligibility groups, Federal law and regulations give states many options.

2. West Virginia Administrative Code

West Virginia's Administrative Code also provides overall guidance and structure for UM, for example, Chapter 9 of the code delineates the duties and responsibilities of the Secretary of the Department of Health and Human Resources to develop Medicaid monitoring and case management. Among these responsibilities is identification of services requiring preauthorization for Medicaid reimbursement (§9-2-9 (3) (b) (10), and developing policy concerning the department's procedures for compliance, monitoring and inspection (§9-2-9 (3) (b) (12). §9-2-9b (a) authorizes the secretary to execute a contract to implement professional health care, managed care, actuarial and health care-related monitoring, quality review/utilization, claims processing and independent professional consultant contracts for the Medicaid program.

§16-29D-3 (a) directs departments and divisions of the state, including, among others, the division of health and the division of human services within the department of health and human resources to cooperate in order, among other things, to ensure the quality of the health care services delivered to the beneficiaries of the departments and divisions and to ensure the containment of costs in the payment for services.

While the code (§16-29D-3 (b) expressly recognizes that no other entity may interfere with the discretion and judgment given to the single state agency which administers the state's Medicaid program, it incorporates the Medicaid program to the extent possible. The departments and divisions shall develop a plan or plans to ensure that a reasonable and appropriate level of health care is provided to the beneficiaries of the various programs including to the extent permissible, the state Medicaid program (§16-29D-3 (c). The plan or plans may include, among other things, utilization review and quality assurance programs (§16-29D-3 (c) (1).

There is also relevant legislation in the code that recognizes that West Virginia's behavioral health system is in crisis, supports the need to improve the system, and provides mechanisms by which to do so.

In Chapter 16, Article 42, (§16-42-1-§16-42-7) the Legislature found that "(1) the behavioral health system in West Virginia is rapidly moving toward a state of crisis as a result of overcrowding of beds in state facilities and prisons, and inadequate community support services to prevent these problems; (2) Untreated and inadequately treated behavioral illness and substance abuse and ongoing domestic violence have placed a significant impediment upon West Virginia businesses and heavy fiscal pressures on many West Virginia government and non-profit agencies; and (3) These untreated problems and lack of services are directly linked to increases in fatalities, penal incarcerations, suicides, utilization of public assistance, homelessness, increased school dropout rates, teenage pregnancy, excessive employee absenteeism, underemployment, unemployment, higher workers' compensation costs and many other health, criminal justice, social and personal

problems which cost our state millions of dollars each year." The Legislature's purpose is to encourage the long-term, well-planned development of a comprehensive and cost-effective system of care.

As a result, effective May 1, 2009 the Legislature reestablished the Comprehensive Behavioral Health Commission within the Department of Health and Human Resources to continue the study of the current behavioral health system, including substance abuse and domestic violence when those conditions have an effect upon or are impacted by the system. The commission is charged with studying the current status of prevention, treatment, education, related services and appropriate workforce development for behavioral health, including substance abuse and domestic violence when those conditions have an effect upon the system. Each item studied is to be reported for children, adults, and seniors. The report is to include recommendations on system changes needed to meet the needs of those served by the system and a determination of the total public and private dollars spent for each item listed in this section. The commission may coordinate its activities with the Department of Health and Human Resources and its consultants. The commission is to submit the report on its study, including recommendations, to the Governor and the Legislature by January 1, 2011. Recommendations are also to include recommendations relating to certificate of need standards.

Among the responsibilities of the Secretary of the Department of Health and Human resources is identification of services which reduce the need for more costly options for necessary care and retention or expansion of those programs (§9-2-9 (a) (9).

§9-5-19 (a-g) outlines circumstances under which a certificate of need may not be required for an entity proposing additional behavioral health care services, except to the extent necessary to gain federal approval of the Medicaid MR/DD waiver program. The code outlines requirements under which a summary review could replace the certificate of need process.

Prior to initiating any summary review, the secretary shall direct the revision of the state mental health plan as required by law. In developing those revisions, the secretary is to appoint an advisory committee composed of representatives of the associations representing providers, child-care providers, physicians and advocates. The secretary shall appoint the appropriate department employees representing regulatory agencies, reimbursement agencies and oversight agencies of the behavioral health system.

If the Secretary of the Department of Health and Human Resources determines that specific services are needed but unavailable, he or she shall provide notice of the department's intent to develop those services. Notice may be provided through publication in the state register, publication in newspapers or a modified request for proposal as developed by the secretary.

The secretary may initiate a summary review of additional behavioral health care services, but only to the extent necessary to gain federal approval of the Medicaid MR/DD waiver

program, by recommending exemption to the health care authority. The recommendation is to include the following findings:

a. That the proposed service is consistent with the state health plan and the state mental health plan;
b. That the proposed service is consistent with the department's programmatic and fiscal plan for behavioral health services;
c. That the proposed service contributes to providing services that prevent admission to restrictive environments or enables an individual to remain in a nonrestrictive environment;
d. That the proposed service contributes to reducing the number of individuals admitted to inpatient or residential treatment programs or services;
e. If applicable, that the proposed service will be community-based, locally accessible, provided in an appropriate setting consistent with the unique needs and potential of each client and his or her family and located in an area that is unserved or underserved or does not allow consumers a choice of providers; and
f. That the secretary is determining that sufficient funds are available for the proposed service without decreasing access to or provision of existing services. The secretary may, from time to time, transfer funds pursuant to the general provisions of the budget bill.

The secretary's findings shall be filed with the secretary's recommendation and appropriate documentation. If the secretary's findings are supported by the accompanying documentation, the proposal does not require a certificate of need.

Any entity that does not qualify for summary review is subject to a certificate of need review.

Any provider of the proposed services denied authorization to provide those services pursuant to the summary review has the right to appeal that decision to the state agency.

§27-1A-1 delineates policy to improve the administration of the state hospitals, raise the standards of treatment of the mentally ill and mentally retarded in the state hospitals, encourage the further development of outpatient and diagnostic clinics, establish better research and training programs, and promote the development of mental health. §27-1A-7 establishes the division of community services within the department of mental health and outlines the powers and duties of the supervisor, one of which is to establish standards for and supervise the operation of community mental health clinics for adults and children and to develop new community facilities and community service programs for the overall improvement of the regional mental health facilities.

Findings

The West Virginia Code, much like federal regulations, provides an overall framework for UM. Development of specific program policies, procedures, and practices is delegated to states in the federal regulations and to state agencies in the West Virginia regulations.

As a result, the state has latitude in terms of both what Medicaid mental health services it offers and how its UM program is implemented. Significantly, the code also acknowledges that the mental health system is in crisis and well-planned changes are needed.

There were no discrepancies noted between the information in the code and either the BMS manuals reviewed or the APS UM guidelines. These reviews are described further in the following sections.

3. Bureau of Medical Services Manual Review Summary

BMS asked CSM to review BMS manuals against the APS UM guidelines for consistency. The following manuals were reviewed: Chapter 502: Behavioral Health Clinic Services, Chapter 503: Behavioral Health Rehabilitation Services, Chapter 523: Targeted Case Management Services, Chapter 400: Member Eligibility, and Chapter 800: General Administration.

Findings

Chapter 502: Behavioral Health Clinic Services, and Chapter 503: Behavioral Health Rehabilitation Services

The manuals are generally consistent with APS guidelines, with some exceptions, outlined below. In some cases, the BMS manuals do not include specific admission, continued stay, and discharge criteria; in these instances, the manuals incorporate the APS guidelines by reference.

B. Discrepancies

Mental Health Comprehensive Medication Services:

- BMS manuals specify that methadone is not a covered service. APS guidelines do not specify this.

Behavioral Health Counseling, Supportive Group:

- BMS manuals specify maximum group size as 12 persons. APS guidelines do not specify group size.

Community Psychiatric Supportive Treatment:

- The BMS manuals specify that methadone administration is not covered. The APS guidelines do not include this.
- With regard to continued stay criteria for medication management/active drug or alcohol withdrawal, the APS guidelines specify criteria specific to medical supervision and withdrawal symptoms, while the criteria under this category in the BMS manuals is the same as criteria listed under danger to self/others and is not specific to drug or alcohol withdrawal.

- With regard to billable activities, the APS guidelines include time spent interviewing family members or significant others either in face-to-face contact or by telephone as billable, while the BMS manual does not specifically delineate this as a billable activity.

Comprehensive Community Support Services:

- APS guidelines state that services are to be available five days a week for maximum of four per day. The BMS manual (Chapter 503) does not specify operating hour requirements.

Day Treatment:

- The BMS manual (Chapter 503) requires that progress on all objectives be reviewed at 90 day intervals and that any objective that results in no progress (or desired change) after two consecutive 90 day intervals must be discontinued or modified. The APS admission criteria includes: "a reasonable expectation that the member can improve demonstrably within three months." Under additional service criteria, the APS manual includes the same language as the BMS manual. This language implies that even though progress must be reviewed every 90 days, progress may not occur for six months.

Chapter 523: Targeted Case Management Services

This manual is consistent with APS guidelines. However, there are opportunities for modifying the requirements described further in the next section under Summary of State Plan Document Review.

Chapters 400: Member Eligibility and 800: General Administration

These manuals were reviewed for denial and appeal guidelines. Chapter 400 provides contact information for members wishing to request a fair hearing. Issues concerning medical necessity may be appealed through the reconsideration process to the UM contractor. Chapter 800 includes guidelines regarding service denial appeals and timeframes. It provides a brief description of the DHHR Agency Fair Hearings. It also describes the provider document/desk review process and the process and requirements for requesting an evidentiary hearing if the provider disagrees with the decision of the document/desk review. The APS medically necessary service provider manual includes the policy for reconsiderations, and a two level appeals process of prior authorization decisions. It also outlines the process for third level appeals through the DHHR Fair Hearing process and requirements for continuing services and payment for members already receiving the service(s) at the time of the review, reconsideration, and appeal process. These policies and process are consistent with BMS and federal guidelines.

C. State Plan Document Review

States are required to submit their Medicaid State Plan to CMS for review and approval. Among other requirements, the State Plan documents describe the optional services the state has elected to provide, providers eligible to provide the services, eligibility criteria for receiving services, utilization control procedures, and payment methodologies. Revisions to the State Plan are submitted through amendments to CMS for approval.

CSM reviewed West Virginia's State Plan documents against the APS UM guidelines for consistency. The following state plan documents were provided by BMS:

- Rehab
- ACT Pending
- Targeted Case Management
- Personal Care

Rehab:

Crisis Services, Counseling, Behavior Management Services (also known as Therapeutic Behavioral Services), and Basic Living Skills Development (also known as Skills Training and Development):

- The APS service definitions for these services are consistent with the service descriptions in the State Plan. The State Plan does not include detailed UM guidelines for these services.

Community Focused Treatment (also known as Comprehensive Community Support Services):

- The State Plan document states services are to be available a five days a week for a minimum of four hours per day. APS guidelines state that services are to be available five days a week for maximum of four hours per day.

ACT (Pending):

- The State Plan document includes eligibility criteria for individuals with a primary diagnosis of mental illness and a secondary diagnosis of mild mental retardation. Current APS guidelines exclude the disability group mental health and mental retardation/developmental disability.
- The State Plan identifies individuals in an eligible disability group with a coexisting substance abuse disorder of significant duration (greater than six months); at high risk or recent history of criminal involvement; and significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless as eligible for ACT. The APS guidelines state that individuals with these issues may be evaluated on a case-by-case basis.

Targeted Case Management:

The State Plan document does not specify frequency of face-to-face contact. Both the APS guidelines and the BMS manual specify that face-to-face contact must occur at a minimum once per month.

CSM contacted Jean Close with CMS to clarify federal requirements regarding targeted case management. West Virginia includes a separate and distinct component of advocacy in its

definition of targeted case management. CMS indicated that advocacy is considered to be an indirect component in each aspect of targeted case management rather than a separate component of the service. Advocacy is "embedded" and encouraged. Federal regulations do not specify a required frequency for face-to-face contact, with the exception of monitoring which must be annually at a minimum. States do have flexibility in defining the frequency of face-to-face contact and may require greater frequency than specified in federal regulations.

Personal Care

APS is not responsible for UM for personal care services and guidelines for this service were not reviewed. The State Plan document does not specifically reference persons with behavioral health disorders. However, the BMS Behavioral Health Rehabilitation Services manual (Chapter 503) does include a section on personal care services and their relationship to behavioral health rehabilitation services.

Personal care services are specific medically necessary activities or tasks ordered by a physician which are implemented according to a nursing plan of care developed and supervised by a registered nurse. They may be provided by behavioral health rehabilitation staff according to the personal care services manual (Chapter 517). This chapter includes the Social Security Administration's definition of disability indicating that persons with a behavioral health disorder may receive these services given that providers meet the requirements outlined in the manual. The disability definitions are:

"An individual who is age 18 or over is considered to be disabled if he is unable to engage in any substantial gainful activity due to any medically determined physical or mental impairment, which has lasted or can be expected to last for a continuous period of not less than 12 months, or can be expected to result in death.

The child who is under age 18 is considered to be disabled if he/she has a physical or mental impairment which can be expected to last for at least 12 months and which severely interferes with his process of maturation. Maturation refers to skills and emotional and social development."

Findings

With very few exceptions, West Virginia's UM guidelines are consistent with both its State Plan and BMS manuals. However, there are opportunities for more flexibility, particularly with regard to targeted case management, and day treatment. The ACT requirements have recently been modified to provide increased access to additional eligibility groups, and APS will need to incorporate these changes into its UM guidelines. There may be a potential for expanding personal care services, but the appropriateness and feasibility of doing so should be should be evaluated further within the context of service delivery system needs as a whole.

In addition, CSM identified other opportunities for flexibility in its review of medical necessity criteria and UM guidelines for comparison programs as described in the next section.

V. MEDICAL NECESSITY AND UM GUIDELINE REVIEW: A COMPARISON OF WV WITH THREE OTHER STATES

In CSM's experience, Medicaid service types, related medical necessity criteria and corresponding UM guidelines routinely have common elements from one state to another. They often also have variations. To better understand these variations, and how West Virginia might modify its guidelines to increase access to services, CSM selected three other state Medicaid programs to compare with West Virginia. This section describes the methodology used for selecting comparison states, and provides definitions of medical necessity for each comparison program, brief overviews of each UM program, and summary and recommendations.

A. Methodology for Selection of Comparison States

CSM conducted preliminary research for a total of 26 states. Targeted states were reviewed for program features including best practices, similarities to West Virginia in terms of demographics and geography, contractors, availability of UM guidelines for review, and medical necessity definitions. Cindy Beane with the BMS also provided input and indicated that states selected need to have been reviewed by the CMS within the last five years in order to avoid making recommendations as a result of the comparison that CMS has disallowed in other states.

Information gathered was based on internet research of state departments/divisions responsible for Medicaid and behavioral health, behavioral health managed care/ASOs, and managed care organizations as well as discussions with colleagues knowledgeable about particular state programs. In addition, available CMS reports on Comprehensive Program Integrity Reviews and Payment Error Rate Measurement reviews were examined to identify any potential implications for this project.

States were eliminated from the pool of possible states for a variety of reasons, such as no requirement for preauthorization for behavioral health services, unavailability of UM guidelines, no ASO or similar contractor, recent concerns voiced by providers and/or consumers regarding program management, and intensive CMS scrutiny of some aspect of the state's Medicaid program.

As result of these reviews, CSM selected the Nebraska ASO, the Iowa Plan for Behavioral Health, and the Texas NorthSTAR program, as states for UM guideline comparison. Nebraska was selected in part, because it contracts with a statewide ASO similar to APS. Unlike an ASO, both the Iowa Plan and the Texas NorthSTAR program are funded through risk-based contracts. In discussions with BMS it was determined that the primary concern was whether or not the comparison programs had had recent disallowances rather than contractual funding mechanisms or geographic area covered. All three programs are representative of how services and UM can be configured to support consumers living in the community and avoid over utilization of restrictive levels of care, while at the same time meeting federal requirements. In addition, the Iowa Plan is widely considered a model program nationally, and the Texas NorthSTAR program includes a broader array of services specifically designed for persons with a serious mental illness.

CMS regional offices confirmed that these states have not had disallowances related to behavioral health clinic, rehabilitation, or targeted case management services in the last five years.

B. Medical Necessity Definitions for West Virginia and Comparison Programs

Medical necessity definitions provide the overall foundation for the application of specific UM guidelines and service authorization and are subject to approval by CMS.

Findings

All of the programs reviewed, including West Virginia, have some common elements in their medical necessity definitions, including services that are:

- appropriate and necessary for the treatment of an illness
- provided for diagnosis or direct care of an illness
- within the standards of good practice
- not provided for the convenience of the recipient or provider
- provided at the most appropriate or least restrictive of care that can be safely provided.

BMS also provides factors to consider in making medical necessity determinations in its behavioral health clinic and rehabilitation manuals, including diagnosis, clinical stability, level of functioning, and availability of support system.

In addition, Nebraska expands on the definition of medical necessity specific to psychiatric rehabilitation by including services that are consistent in type, frequency, duration of service with accepted principles of psychiatric rehabilitation, and services that can reasonably be expected to increase or maintain the level of functioning in the community of clients with severe and persistent mental illness. The Iowa Plan and Texas NorthSTAR definitions also make reference to the potential for services to enable a recipient to maintain level of functioning.

The Iowa Plan incorporates psychosocial necessity into its definition of medical necessity by including not only clinical factors, but environmental factors and unique circumstances.

In general, the other states reviewed all have broader definitions of medical necessity for behavioral health services than West Virginia as shown below.

Medical Necessity Definitions	
West Virginia	BMS utilizes the following definition of medical necessity, services and supplies that are: Appropriate and necessary for the symptoms, diagnosis or treatment of an illness

	Provided for the diagnosis or direct care of an illness Within the standards of good practice Not primarily for the convenience of the plan member or provider The most appropriate level of care that can be safely provided For behavioral health clinic and rehabilitation services the Bureau of Medical Services manuals outline factors related to medical/clinical necessity determinations. For these types of services, the following four factors will be included as part of this determination as appropriate: Diagnosis (as determined by a physician or licensed psychologist) Level of functioning Evidence of clinical stability Available support system Consideration of these factors in the service planning process must be documented and reevaluated at regular service plan updates. Diagnostic and standardized instruments (as approved by BMS) must be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record and as documentation of service need and justification for the level and type of service provided.[15]
Nebraska	Health care services and supplies which are medically appropriate and • Necessary to meet the basic health needs of the client; • Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; • Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies; • Consistent with the diagnosis of the condition; • Required for means other than convenience of the client or his or her physician; • No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; • Of demonstrated value; and • No more intense level of service than can be

[15] http://apshealthcare.com/publicprograms/west_virginia/WV_Prov_Medically_Nec_Service.htm.
West Virginia Department of Health and Human Resources Provider Manuals, Chapters 502, 503: Behavioral Health Clinic Services and Behavioral Health Clinic Rehabilitation Services.

	safely provided. Nebraska further defines medical necessity for rehabilitative psychiatric services as follows: For purposes of covering rehabilitative psychiatric services, the following interpretative notes apply. Medical necessity for rehabilitative psychiatric services includes health care services which are medically appropriate and • Necessary to meet the psychiatric rehabilitation needs of the client; • Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; • Consistent in type, frequency, duration of service with accepted principles of psychiatric rehabilitation; • Consistent with the diagnosis of the condition; • Required for means other than convenience of the client or his or her service provider(s); • No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; • Of demonstrated value; and • A no more intense level of service than can be safely provided. Rehabilitative psychiatric services are medically necessary when those services can reasonably be expected to increase or maintain the level of functioning in the community of clients with severe and persistent mental illness.
Iowa	Iowa Medicaid defines medically necessary as services that are: • Consistent with the diagnosis and treatment of the member's condition; • Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver; • The least costly type of service that can reasonably meet the medical needs of the member; and • In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

	– Knowledgeable Iowa clinicians practicing or teaching in the field; and – The professional literature regarding best practices in the field. The Iowa Plan definition also incorporates psychosocial necessity as follows: Psychosocial necessity shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be: • Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis. • Provided for the diagnosis or direct care and treatment of a mental disorder. • Within standards of good practice for mental health treatment. • Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor. • The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner. The determination of psychosocial necessity shall be made after consideration of the enrollee's clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g., availability of transportation, lack of natural supports including a place to live); and the enrollee's choice of provider or treatment location.[16] [17]
Texas NothSTAR	Behavioral health services which: • Are reasonably necessary for the diagnosis or treatment of a mental health or chemical dependency disorder or to improve, maintain or prevent deterioration of functioning resulting from such a disorder • Are in accordance with professionally accepted

[16] Nebraska Administrative Code, Title 471, Chapter 35, Rehabilitative Psychiatric Services

[17] Iowa Administrative Code, Title 441, Chapter 78, Human Services, Chapter 88, Managed Care Providers.

	clinical guidelines and standards of practice in behavioral healthcare • Are furnished in the most appropriate and least restrictive setting in which services can be safely provided • Are the most appropriate level or supply of service which can safely be provided • Could not have been omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered. [18]

1. UM Guideline Review

Please refer to Appendix 2 through Appendix 5 for more detailed UM guideline information for each of the comparison programs. These are intended to provide an overview of UM guidelines for each program related to adult clinic, rehabilitation option, and targeted case management services. Guidelines for other behavioral services and guidelines specifically related to children and adolescents are excluded.

UM guidelines are composed of several components that together provide the structure for making determinations about what services are likely to benefit recipients at the least restrictive and most cost-efficient level of care. They also help to avoid inappropriate service delivery, for example, interventions that are not specifically designed to target a person's symptoms or level of functioning; and assist in avoiding duplication of services, for example, the same services being provided by multiple providers during the same time frame. Specific components of the guidelines that were reviewed include:

- Service type/description
- Diagnostic criteria
- Admission and continued stay criteria
- Coordination of care requirements
- Review frequency
- Documentation requirements

In addition to these components, all programs include exclusion and discharge criteria for each service. These are not included in the appendices as they are very similar across all states and services and can be summarized as:

Exclusion criteria:

- Member is not a member of target population for a particular service
- Member does not meet diagnostic criteria
- Member does meet age criteria
- Member's physical or mental impairments prevent participation in service

[18] Texas Administrative Code, Title 25, Chapter 419, Health Services.

- Service cannot be provided concurrently with another service
- Intensity, frequency, and type of services are not appropriate for the member's age and functional level
- Service cannot be provided for a primary physical health condition.

Discharge criteria:

- Member/family choice or request to terminate service
- Treatment goals have been met or substantially met
- Need for more or less restrictive levels of services
- Member unwilling or unable to participate in treatment/services/activities
- Lack of reasonable expectation for improvement
- Member relocated to another state/geographic area.

Please note that while service codes are identified in Appendix 2 through Appendix 5, they are not necessarily consistent across states and services. One reason for this is that service-related terminology is sometimes inconsistent across programs. Secondly, the Patient Protection and Affordable Care Act requires that State Medicaid programs to incorporate National Correct Coding Initiative methodologies in their claims processing systems by October 1, 2010. However, states are at various stages in implementing these requirements.

In addition to the UM guidelines, CSM reviewed policies and procedures related to denials and appeals and these are summarized in the brief program overviews below.

a. Overview of APS Healthcare's West Virginia UM Program

APS Healthcare is the statewide ASO for West Virginia and provides UM services for mental health and substance services. CSM reviewed West Virginia's BMS Medicaid Manuals, state plan documents, APS UM guidelines and provider manuals, forms, training materials, newsletters, and related reports[19] [20] [21] [22] [23] UM guidelines are in place for the following services in West Virginia:

West Virginia Utilization Management Guidelines
Crisis Intervention
Mental Health Assessment by a Non-Physician
Screening by Licensed Psychologist
Psychological Testing with Interpretation and Report
Developmental Testing: Limited

[19] http://www.cms.gov/MedicaidNCCICoding/
[20] http://www.wvdhhr.org/bms/Manuals/bms_manuals_main.htm
[21] IRG/APS Healthcare Utilization Management guidelines for West Virginia Medicaid Clinic, Rehabilitation, Targeted Case Management Options, Version 3.0, May 2010.
[22] APS Administrative Services Organization Provider Operations Manual for Medically Necessary Services, Version 1.0
[23] APS Provider Consultations: Overview and Analysis, Behavioral Health Outpatient Providers, February 1-July 31, 2009. Authorization Reports, August 2010. Annual Behavioral Health Outpatient Providers Satisfaction Survey Results, 2008-2009. Provider Training Summary, 2008-2009. Provider Technical Assistance Summary, 2008-2009

Psychiatric Diagnostic Interview Examination
Pharmacological Management
Mental Health Comprehensive Medication Services
Mental Health Service Plan by Non-Physician (Psychologist Participation)
Physician Coordinated Oversight Services
Behavioral Health Counseling, Professional/Supportive Individual/Group
Case Consultation
Targeted Case Management
Comprehensive Community Support Services
Day Treatment
Assertive Community Treatment (ACT)
Skills Training & Development Paraprofessional/Professional
Therapeutic Behavioral Services-Development/Implementation
Community Psychiatric Supportive Treatment

APS uses a multi-tiered system for prior authorization and providers submit required data electronically via CareConnection, a web-based system. Additional data elements are required as the clinical complexity and service levels increase for a member. Tier 1 requires minimal data elements, and is used to validate a member's eligibility to receive a specific service. No clinical review is required at this tier, however, the request could be "pended" for review in certain circumstances, for example, the member is receiving the same service from a different provider, or benefits for the service have been exhausted. At Tier 2, the number of data elements required for authorization increases. The intensity of service may be minimal but the need for continued stay warrants further review. Tier 3 is used for more complex cases and Tier 4 is used for the most intensive services.

Requests may be automatically authorized if validated through CareConnection. Requests that are not validated are pended for further review. For cases in which criteria for the service is not met, a renegotiation may occur between the provider and the licensed APS care manager to reach agreement on a change in services. If a non-authorization decision is made, the provider may request a reconsideration, and if a denial decision is made, the provider may request an appeal. APS reports that there have been approximately 200 denials over the last ten years but does not track or report the number of renegotiations.

In addition to data submitted for prior authorization, providers maintain a treatment record for each member receiving services. APS conducts retrospective consultations of provider internal documentation practices through treatment record reviews on a sample of records using standardized review procedures, tools, and scoring protocols. Documentation requirements are made available to providers through the website and various trainings. Providers are given the results of these reviews, and APS provides training and technical assistance to support providers in improving performance. Scores that fall below specified thresholds result in authorization adjustments. Authorization adjustments are used for services that have been prior authorized, but the treatment record documentation is insufficient to justify the authorization. Providers have the opportunity

to make corrections and request a new authorization. Authorization adjustment data is provided to the State's Contract Management, which includes BMS and may result in a "payback." Providers have the opportunity to appeal these decisions through the APS appeals process, and if the provider disagrees with the decision, an appeal may be filed with the State's Contract Management.

Care coordination requirements are specified for some services, for example, targeted case management, and not for others. There is no formal policy in place that addresses overall care coordination. The UM guideline manual makes reference to the provider's responsibility to coordinate care in general. In discussions with APS leadership and clinical staff, it was pointed out that care managers do work with providers to coordinate care and that care coordination at the member level will be a focus for the current contract cycle. Previous efforts at coordination have been focused on the agency level.

b. Overview of Nebraska's UM Program

Nebraska contracts with a statewide ASO (Magellan) to conduct UM services for mental health and substance services. CSM reviewed Nebraska's Department of Health and Human Services, Division of Medicaid and Long Term Care UM guidelines for adult behavioral health services, state program service descriptions, rules and regulations, Medicaid manuals, and provider bulletins.[24] [25] [26] UM guidelines are in place for the following services in Nebraska:

Nebraska Utilization Management Guidelines
Pharmacological Management
Behavioral Health Counseling, Professional/Supportive Individual /Group
Comprehensive Community Support Services
Day Treatment
Assertive Community Treatment (ACT)
23 Hour Crisis Observation, Evaluation, Holding, and Stabilization
Crisis Stabilization
Intensive Outpatient Service
Psychiatric Residential Rehabilitation
Day Rehabilitation
Mental Health Home Health
Secure Residential Rehabilitation
Customer Assistance Program (CAP)

[24] Nebraska Health and Human Services System, Division of Behavioral Health Services, Medicaid Division Adult Mental Health System Service Definitions and Utilization Guidelines, August 2006.
[25] Nebraska Health and Human Services Finance NMAP Services and Support Manual, Chapter 35-000 Rehabilitative Psychiatric Services, October, 2003.
[26] http://www.hhs.state.ne.us/med/medindex.htm

For outpatient services, providers may request preauthorization for a pretreatment assessment (diagnostic interview and biopsychosocial assessment) or for a maximum of five customer assistance program (similar to employee assistance programs) sessions telephonically. A clinical review is not required for these services. For additional outpatient services (with the exception of medication management), the provider submits a treatment request after the pretreatment assessment has been completed. Twenty-four sessions are authorized over two six-month periods, and if additional sessions are required, a clinical review is conducted by an ASO care manager. For medication management, routine retrospective reviews are conducted, and concurrent reviews may be conducted on an exception basis for more complex cases. More intensive levels of care are reviewed telephonically and the frequency of these reviews is individualized based on the consumer's needs, rather than at specified intervals.

For authorization requests that result in a denial, the provider is given the opportunity to appeal the decision, and if the denial is upheld, the provider may request a reconsideration. If the provider is not satisfied with the outcome of the reconsideration, he or she may request a state fair hearing. Information on how to request an appeal, reconsideration, or state fair hearing is posted online and in notification letters throughout the process.

Retrospective reviews of providers' treatment records are also conducted by the ASO using a standardized tool, and the results of these reviews are used to identify opportunities for improvement and provider training needs. Nebraska also conducts post-payment reviews of provider records to ensure that services were rendered according to policy. Providers whose records are not in compliance with policy may be sanctioned and payments may be recouped.

Please note that Nebraska does not offer targeted case management for adult behavioral health services, but does offer a continuum of rehabilitation option and clinic services as shown in Appendix 3. Note also that since frequency of reviews for most services is individualized, average length of stay instead of review frequency has been included if available. Nebraska's UM guidelines also include components not shown in the attachment that are common to all services, such as:

The requirement that services be culturally appropriate (which may change the type and duration of treatment)
Documentation that must be included in all provider clinical records regardless of the level of care (demographic information, pretreatment assessment, treatment plan with measurable goals and objectives, progress notes, discharge plan, coordination of care).

c. Overview of Iowa's UM Program

CSM reviewed Iowa's Department of Human Services, Iowa Medicaid Enterprise manuals, state program service descriptions, rules and regulations, and general letters.[27] [28]

[27] State of Iowa Department of Human Services, Medicaid Provider Manuals, Community Mental Health Center, 2003, Remedial Services, 2008, Behavioral Health Services, 2008, Psychologist Services, 1998.

[29] The statewide Iowa Plan for Behavioral Health is managed by Magellan. The company conducts UM for mental health and substance abuse for members in the plan, which includes most Medicaid members in the state. UM for Medicaid members who are not in the plan is conducted by the state Medicaid agency. UM guidelines are in place for the following services in Iowa:

Iowa Utilization Management Guidelines
Psychological Testing with Interpretation and Report
Behavioral Health Counseling, Professional/Supportive Individual /Group
Targeted Case Management
Comprehensive Community Support Services
Day Treatment
Assertive Community Treatment (ACT)
Skills Training & Development
23 Hour Crisis Observation, Evaluation, Holding, and Stabilization
Crisis Stabilization
Intensive Outpatient Service
Mobile Crisis Services
Intensive Psychiatric Rehabilitation
Respite
Peer Support
Telehealth
Mobile Counseling
Integrated Mental Health Services & Supports

For authorization requests that result in a denial in whole or in part, the provider is given the opportunity to appeal the decision. If the provider is not satisfied with the outcome of the appeal, he or she may request a state fair hearing. Information on the appeals and state fair hearing process is posted online and in appeal decision letters.

Retrospective reviews of providers' treatment records are also conducted using a standardized tool, and the results of these reviews are used to identify opportunities for improvement and provider training needs. Iowa also conducts post-payment provider claims reviews to ensure that services were rendered according to policy. Providers whose claims are not in compliance with policy may be sanctioned and payments may be recouped.

Magellan's specific UM guidelines for services are proprietary and, as such, the company's detailed criteria are not presented in the following table. A summary of the key elements of the criteria include:

- A DSM-IV TR diagnosis is required for services other than evaluation/testing.

[28] Iowa Administrative Code, Title 441, chapters 24, 78, 88
[29] http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/medprovgl.htm

- Individualized frequency of review/authorization is based on the member's need, rather than authorization at specified intervals based on the service.
- Individualized lengths of stay based on the member's needs.
- A strong focus on recovery and community tenure using community-based services and supports.
- An emphasis on socio-cultural appropriate services.
- A reasonable expectation for improvement. However, no specific timeframes for improvement are incorporated into the guidelines.
- Documentation that must be included in all provider clinical records regardless of the level of care (demographic information, assessment, treatment plan with measurable goals and objectives, progress notes, discharge plan, coordination of care).

Appendix 4 includes brief service descriptions for those services not specifically delineated in state regulations. More detailed information is included for those services outlined in state manuals and regulations. These include day treatment, outpatient services, community support, skill training and development, ACT, and case management.

d. Overview of the Texas NorthSTAR UM Program

The Texas NorthSTAR is a managed behavioral health program that covers seven counties in the Dallas, Texas area. ValueOptions is contracted to provide UM services. CSM reviewed Texas Medicaid and Healthcare Partnership Medicaid provider manuals, clinical policies and procedures, level of care guidelines (UM guidelines), rules and regulations, and provider bulletins.[30] [31] [32] Level of care guidelines are in place for the following services in Texas NorthSTAR:

Texas NorthSTAR Level of Care Guidelines
Crisis Intervention
Psychological Testing with Interpretation and Report
Pharmacological Management
Mental Health Comprehensive Medication Services
Behavioral Health Counseling, Professional/Supportive Individual /Group
Targeted Case Management
Comprehensive Community Support Services
Day Treatment
Assertive Community Treatment (ACT)

[30] Texas Medicaid Provider Procedures Manual: Volume 2, Behavioral Health, Rehabilitation, and Case Management Services Handbook, 2010.
[31] http://www.hhsc.state.tx.us/medicaid/
[32] ValueOptions Level of Care Criteria, 2006, Provider Manual, 2004

Texas NorthSTAR Level of Care Guidelines
Skills Training & Development
23 Hour Crisis Observation, Evaluation, Holding, and Stabilization
Intensive Outpatient Service
Mental Health Home Health
Mobile Crisis Services
Respite
Supported Employment
Adult Foster Care
Hospital-Based Crisis Stabilization
Community-Based Crisis Stabilization
Intensive Crisis Residential
Personal Care Homes/Assisted Living
Psychosocial Rehabilitation

In addition to the services requiring authorization, the following services are available:

- Consumer Run Drop-In Centers
- Minority and Specialty Populations Outreach
- Family Support Groups
- Peer Education Support and Counseling
- Dual Diagnosis Support Groups.

Authorization for most intensive levels of care is conducted telephonically. Providers are responsible for contacting the contractor to request authorization. Authorizations for rehabilitative and supportive services are provided by a specialty provider network (SPN) specifically contracted to provide services to target populations require the SPN to complete a WebCare Uniform Assessment and Texas Recommended Assessment Guidelines scores (TRAG) with a treatment plan (if requested). The TRAG is a systematic assessment process for measuring mental health service needs based on the most recent diagnosis and nine dimensions. It is a method for quantifying the assessment of service needs to allow reliable recommendations into the various levels of care or service packages with specified types and amounts of services.

Authorization is required for outpatient services beyond three visits per year. For outpatient authorizations which require additional clinical information providers submit the treatment plan by fax. Frequency of review is determined by the consumer's clinical status and assessment scores.

During authorization reviews, care managers request clinical information about the consumer's condition and response to treatment in order to determine that the requested level of service is medically necessary. If a care manager cannot authorize the request due to lack of medical necessity, he or she may discuss alternative levels of care or treatment plans that could be authorized. If the provider disagrees with these recommendations the case is referred to a peer advisor with expertise in the area under review for a peer review. If the peer advisor makes a denial determination, the provider is

given the opportunity to request a reconsideration. If the denial is upheld, the provider may request a Level I appeal. If the denial is upheld at this level, the provider may request a Level II appeal. Information regarding the reconsideration and appeals process is posted online and in notification letters.

Guidelines that apply to all services include:

- Although the guidelines include specific diagnostic requirements for services, exceptions can be made for consumers who have a demonstrated need for the service even in the absence meeting the diagnostic criteria.
- Specific reference to the consideration of cultural, ethnic, and linguistic factors that may change the type of level of services needed.
- In most cases, the guidelines do not include specific documentation requirements for specific levels of care. Provider manuals do outline requirements for documentation that must be included in all provider clinical records regardless of the level of care (demographic information, assessment, treatment plan with measurable goals and objectives, progress notes, discharge plan, coordination of care).
- With some exceptions, coordination of care requirements are not specified for each service in the guidelines. However, NorthSTAR has detailed polices regarding both provider and contractor responsibilities in this area including policies on:

  - Working with the Department of Family and Protective Services
  - Interface with primary care physicians including memoranda of understanding with health maintenance organizations
  - Access and referral
  - Duty to screen and refer for physical and behavioral health needs
  - Timely, effective, and confidential exchange of information

The contractor conducts treatment record audits of provider sites that meet the selection criteria for treatment record review. Providers may also be randomly selected for site visits or treatment record reviews. Feedback on compliance opportunities is communicated to the provider and if needed, a corrective action plan is implemented.

The contractor also conducts provider audits to determine compliance with contractual standards, state requirements, and clinical guidelines. Compliance with key indicators of quality and performance is evaluated and may include provider qualifications, treatment planning and documentation, program content and oversight of treatment progress, and fidelity of programs and services. Providers are given initial feedback on audit results with a follow-up letter addressing specific audit results and any requested plan of correction.

The state Medicaid agency also conducts retrospective record reviews and may seek recoupment of payment if the record is noncompliant with requirements.

VI. SUMMARY AND RECOMMENDATIONS RELATED TO UM COMPARISIONS OF WV TO THREE COMPARISON PROGRAMS

A. General Findings

All three state comparison programs provide a broader continuum of community-based rehabilitation services than West Virginia. The three comparison programs' UM guidelines stress individual recipients' needs (including cultural needs) into the guidelines to a greater extent than do West Virginia's guidelines. With the exception of UM guidelines for ACT, West Virginia's guidelines do not include a focus on recovery. The comparison programs place a much greater emphasis on recovery and community tenure.

Compared to other states reviewed, West Virginia's UM guidelines are more focused on compliance rather than how services that assist consumers to live in the community and lead meaningful lives can be tailored to individual needs. While regulatory compliance is important and necessary, it should not be the primary focus of UM. Effective UM programs promote access to appropriate services based on an individual's needs and strengths and result in optimal outcomes for consumers, while at the same time managing utilization and costs. This means that authorization decisions take into consideration not only an individual's immediate treatment needs, but long-term strengths, needs, choices, and goals as well. Service authorizations may be for shorter or longer time periods and for different service mixes depending upon where a consumer is at in his or her recovery process. In other words, persons with similar diagnoses and symptoms may require different services due to their unique circumstances. While West Virginia's guidelines for rehabilitation services do include service descriptions that incorporate "interventions which are intended to provide support to the member in order to maintain or enhance levels of functioning,"[33] in practice authorizations are heavily focused on demonstrated improvement in functioning rather than acknowledgement that a service may be required to maintain level of functioning, increase community tenure, and reduce the need for more restrictive levels of care. If justified through documentation that a consumer is likely to deteriorate without continued interventions the service should be authorized.

B. Findings Related to UM Components and Denials and Appeals

Diagnostic Criteria: All programs' UM guidelines include similar diagnostic criteria. Texas NorthSTAR in particular has a process for making exceptions to specific diagnostic criteria for recipients who have need in the absence of a target diagnosis.

Admission and Continued Stay Criteria: Criteria in place for specific services across the comparison programs vary. For example, West Virginia includes guidelines for services such as case consultation, and mental health assessment/mental health service plan by a non-physician. Even though other programs do not include specific criteria for these types of services, they are billable services. Parameters for billing for them are typically outlined in claims submission guidelines.

[33] Behavioral Health Rehabilitation Services Manual, West Virginia Bureau for Medical Services, page 15.

Guidelines for all programs include a "reasonable expectation for improvement" as one element of most admission and continued stay criteria. While this terminology is non-specific, it is a common element of UM guidelines nationally and trained clinicians and clinical supervisors should have the skills necessary to make such a determination by assessing a recipient's motivation and readiness for change, ability to attend and actively participate in services, how interventions and supports can promote improvement, and past response to treatment.

That being said, with some exceptions, for example, crisis services and intensive outpatient services which are time-limited by nature and accepted practice nationally, comparison guidelines do not include specific timeframes for expectation for improvement. Since individuals make progress at different rates, it is impractical to make attempts at predicting how quickly one is likely to improve. West Virginia specifically includes timeframes for improvement for day treatment services and skills training and training and development. While APS indicated that these are "soft limits," specific timeframe requirements do not provide a person-centered approach to service utilization based on individual strengths and needs.

By comparison, for day treatment, Iowa and Texas NorthSTAR UM guidelines do not include specific timeframes for improvement. The typical length of stay for day treatment in Nebraska is two to four months, indicating that some recipients may require much shorter or much longer time periods in which to improve.

For skills training and development, Iowa's guidelines require review of the service plan at six-month intervals or more frequently if warranted, and Texas NorthSTAR provides continued services based on individual re-assessment scores.

Coordination of Care Requirements: Like West Virginia, coordination of care requirements are not always included for each service in UM guidelines for comparison states. Expectations for coordination with primary care providers, community services, and other behavioral health providers are typically incorporated into the authorization process (care mangers address these needs during utilization review) and provider treatment record reviews. Texas NorthSTAR has the most robust coordination of care policies including formal agreements with agencies and health plans that specify roles and responsibilities related to coordination of care and services.

Authorization/Review Requirements: There is a wide variation among the comparison programs with regard to authorization requirements and review frequency. Authorizations may be submitted electronically, via fax, or telephonic requests. Some services do not require authorization or are authorized automatically. Frequency of review also varies; however, it is based on individual needs rather than service type to a greater extent for comparison programs than West Virginia. Clinical information required for authorization purposes is similar across all comparison programs, including West Virginia.

Documentation Requirements: While they may not be specifically incorporated into UM guidelines for the comparison programs as they are in the West Virginia guidelines, documentation requirements are included in other manuals and policies and are similar for both authorization and treatment records to West Virginia's requirements. All contractors conduct

retrospective reviews of provider treatment records to ensure compliance with regulations and policy. In addition, all state Medicaid agencies or their agents conduct treatment record reviews and have processes in place to recoup payment if requirements are not met.

Denials and Appeals: All comparison programs, including West Virginia have denial and appeals policies in place that are consistent with national standards and meet federal guidelines. However, in West Virginia providers report that APS has communicated that denials are highly undesirable and that they are encouraged to accept authorization recommendations made during the APS renegotiation process to avoid a denial for the original request and any subsequent requests for an appeal. While this type of renegotiation process is accepted practice in an ASO environment, it should be made clear that providers have appeal rights. Since APS is not required to track or report renegotiations it is not possible to quantify and evaluate the extent to which actual practice with regard to denials and appeals is consistent with the spirit of the regulations.

C. Recommendations

CSM's review of medical necessity definitions, and UM guidelines resulted in the recommendations below, which if implemented, will in part support recipients in having greater access to recovery-oriented services and promote community tenure. These recommendations primarily address guidelines in place for current services. Another critical gap in the West Virginia system is the limited service array compared to other states. The state has made some progress in this area with the revision of guidelines and processes for ACT, which is an evidence-based practice and will provide a valuable service for consumers who have a serious mental illness. However, as in other states such as Nebraska, the service will likely have limited use in rural areas due to limited resources to meet the model's staffing and administrative requirements. Well-planned development of additional services will be another important step in increasing access to services.

CSM recognizes that some recommendations will require a State Plan amendment. Recommendations include:

a. Develop guidelines similar to the Nebraska ASO and Iowa Plan for the medical necessity of rehabilitation services to fully incorporate psychosocial rehabilitation and recovery principles, which are aligned with national policy promoting community-based rather than institutional services. Include knowledgeable West Virginia providers practicing or teaching in the field in guideline development.

b. Evaluate the feasibility and sustainability of developing a broader service array, such as mental health home health, mobile crisis, medication training and support services, respite, psychosocial rehabilitation, 23 hour crisis observation, evaluation, holding and stabilization, psychiatric residential rehabilitation, and customer assistance program. Service enhancement is especially important in rural areas where ACT will likely be of limited use. Since ACT is an evidence-based practice with very specific requirements and fidelity measures, rural providers often do not have access to the required staffing resources and may not be able to meet caseload requirements.

- Ensure that these innovations will address the needs of a changing population of younger individuals with co-occurring mental health and substance abuse problems.

c. Incorporate the Substance Abuse and Mental Health Services nationally recognized recovery principles into the UM guidelines and authorization process.[34]

d. Revise UM guidelines to remove specific timeframes (particularly for day treatment and skills training and development) for expected improvement and include a focus on individual strengths and needs, recovery, and community tenure.

e. Modify the UM guidelines for ACT to make them consistent with the State Plan document. Remove the requirement for some targeted populations to be authorized for admission on a case-by-case basis.

f. Modify the definition and requirements for frequency of face-to-face contact for targeted case management. Embed advocacy in all elements of the service rather than defining it as a separate service component. Reduce the requirement for frequency of face-to-face contact to once every 90 days and require more frequent face-to-face contact based on individual needs.

g. Evaluate the need for expanded criteria for personal care services specifically for individuals who have needs for these services as a result of a behavioral health disorder.

h. Establish a process for APS to track and report renegotiations and trend over time in order to identify any inappropriate reductions/restrictions related to service authorization.

i. Evaluate and resolve discrepancies noted in the BMS manuals and UM guidelines.

j. Define roles and responsibilities for APS and provider coordination of care with primary care, community agencies and other service providers in order to avoid duplication in service provisions and conflicting treatment and service plans.

VII. REVIEW OF STAKEHOLDER FEEDBACK

A key objective of the current project was to solicit personal feedback and relevant experiences from various stakeholders within the behavioral healthcare system. The primary goal of this process was to gain further perspective on those factors impacting service delivery. Additionally, it allowed CSM the opportunity to concretize findings and opinions identified during the UM Guideline review. A multi-faceted approach was designed, including direct and telephonic interviews with representatives from various stakeholder groups.[35] CSM also briefly visited several community providers and designated diversion hospitals. In addition, both state

[34] http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf
[35] See Appendix 6 for a complete list of all interviewees and facility visits.

hospitals were toured and staff interviewed. An anonymous web-based survey was also completed by representatives from 12 of the Comprehensive Mental Health Centers. Finally, CSM reviewed a number of major reports completed by various consultants, commissions, providers, and other sources.[36] The results and findings from these activities are provided below.

A. Provider Perspective

A critical step in the CSM assessment process was to solicit feedback from various representatives within the state provider system. To identify and adequately understand their perspective and experience with those issues relevant to this project, CSM designed and implemented a multi-pronged approach. Utilizing a structured set of questions, the CEOs from all thirteen Comprehensive Mental Health Centers were interviewed either telephonically or in person. In some instances, additional staff from the Comprehensives participated in the interview process, which also included extensive dialogue on a variety of related topics. In person interviews were further augmented with tours of agency facilities and treatment locations.

To complement the interview process, CSM also designed and conducted a follow-up web-based survey. This electronic survey, which likewise incorporated a series of structured questions, was completed anonymously by representatives from twelve of thirteen Comprehensive agencies. The design and format of the survey effectively enabled the results to be analyzed and statistically compared. The findings and observations from these initiatives follow below.

B. Structured Interview Questions

As indicated above, the CEOs from each of the thirteen Comprehensives were interviewed using a structured set of questions. Feedback and CSM's observations from those interviews are summarized below:

1. Describe the nature of your organization and the types of clients you serve and the programs you offer.

The provider base of West Virginia's community mental health system shares many similarities. The overall range and scope of services being provided tends to be consistent from one catchment area to another. Likewise, the general absence of what might be termed "core" services including day treatment, residential and ACT programs is equally consistent across the state. However, specific differences do exist in the continuum of care offered by individual providers. Population density and the challenges associated with a varying geographic landscape have, along with historical and other cultural factors, created distinct differences among the thirteen Comprehensives. Many of those individuals interviewed indicated that State leadership has failed to effectively consider those differences in previous planning and service implementation.

[36] See Appendix 7 for an annotated list of the reports reviewed for this proposal.

An interesting similarity shared by many of the Comprehensives is the longevity of its current leadership. Most of the CEOs and other executive staff that were interviewed have extensive experience working in the West Virginia community mental health system, some as long as 15 – 30 years. Many, if not most, of these individuals share an historical perspective that pre-dates the Federal Disallowance and have struggled, in their opinion, to effectively meet the needs of consumers in the current restricted environment.

2. Describe the overall planning process for service delivery in WV.

The impression shared by the majority of those interviewed was that recent State efforts to design and implement a comprehensive system of care have been largely fragmented, short sighted, poorly focused on the needs of the consumers, underfunded, at times reactive and ultimately ineffective. Multiple reasons were offered in an attempt to explain these failures with most agreeing that the lack of a current state-planning document was an overwhelming factor. CSM reviewed what was described as the state plan dated 1995.[37] Clearly the absence of a plan, which incorporates the identified limitations and restrictions of the current funding mechanism, significantly impacts the State's ability to meet the needs of consumers.

Most of the executives shared experiences of participating in past planning efforts with various governmental agencies and subsequent implementation of changes to the service delivery system. However, they also felt that previous state efforts to bring all stakeholders together were not proactive enough and failed to achieve consensus. They also repeatedly mentioned the numerous outside consultant reports that have been completed, including the provider sponsored "Crossroads"[38] report. Unfortunately, most felt that the findings of these reports, especially recommendations for planning and implementation strategies have been largely ignored. Most acknowledged that the Hartley Agreed Order held some promise for future focused and improved service delivery systems, but delays in implementation have been frustrating.

There were frequent comments that the Bureau for Behavioral Health and Health Facilities (BHHF) (within the WV Department of Health and Human Services or DHHR) has had frequent leadership changes over the last few years. Many felt that this lack of a shared "historical perspective" limited the ability of the two groups to effectively work together. It was also mentioned that the chronic understaffing of these two governmental agencies significantly impacted their ability to effectively carry out its duties. Two other major government entities, also within DHHR, are the Bureau of Medical Services (BMS) and the Office of Health Facility Licensure and Certification (OHFLAC). Providers consistently identified this as a "multi-headed beast" that seldom operated in a consistent manner when planning for and implementing services. Conflicting demands, lack of a coordinated effort, a strong "silo" mentality, and other administrative difficulties were characteristics used to describe some of the challenges the providers encountered while trying to accommodate and work with these groups.

[37] http://www.hcawv.org/CertOfNeed/Support/Behavioral_Health.pdf

[38] West Virginia's Comprehensive Community Mental Health Centers (2009). *Crossroads: Creating a system of care for adults with mental illness or co-occurring disorders.*

a. What needs are being unmet in the system of care in WV, particularly in your catchment area?
b. What do you attribute this to?
c. How would you change the system to fix these issues?

Frequently, staff and leaders from the Comprehensives commented that what they needed most to fix gaps in the existing continuum of care was access to many of the practices, services, and resources available in the 1980s to 1990s. Typically what they most often identified were more case management type services, residential service options, day treatment type services, and services for those with co-occurring disorders (both mental illness and substance and mental illness and developmental disabilities/intellectual disabilities). Although always somewhat problematic to gain access to, transportation services, especially in the rural areas has become more difficult. The one factor that has changed from past systems of care was that it was more possible to find reimbursement for case managers to engage in transportation efforts than at present.

Most embraced the concept of ACT teams or similar outreach type services, but felt that a somewhat less structured and more flexible program model was necessary. Total fidelity to the ACT model has been challenging, especially the requirement to maintain recommended professional team membership. Interestingly, most noted that they previously performed many "ACT-like" services with their aggressive use of case management.

All felt that current paperwork requirements were excessive and significantly reduced face-to-face time with consumers while also further complicating an already burdensome authorization process. Related to the challenges associated with service authorization, was the observation that the current process mirrors that of a medical model. The authorization of services in short 15 minute intervals is simply not consistent with the delivery of care in the community with consumers diagnosed with severe and persistent mental illness.

In line with the principles of wellness and recovery, many embraced the idea of more peer supports programming. Some elements of these programs do exist across the state, but it is generally a concept that is unrealized to a great extent. CSUs were also a frequent topic of discussion, especially issues associated with a program model that lacks consistency from one agency to another. Some Comprehensives utilize them frequently, but expressed frustration with documentation and reimbursement issues. Other organizations acknowledged underutilization, citing deficiencies with existing facilities and demanding staffing patterns that regularly limit service provision for many consumers who might benefit from this level of care. Still, other Comprehensives indicated that they no longer have or feel they can support a CSU unless there are significant changes in documentation requirements, reimbursement, and the availability of key staff (primarily psychiatric) to properly run such a unit. Despite these concerns there was a common consensus that CSUs, when properly funded and designed with adequate facilities, can play a vital role in the community system of care especially as an alternative to hospitalization.

Ironically, many of those interviewed indicated that the real issues impacting the State's system of care were more fundamental than just the apparent problems associated with the current Medicaid-funding mechanism. As challenging and frustrating as that mechanism may be on a day-to-day basis, the lack of proper planning and coordination at the State level was identified as the real problem. Specifically, the absence of planning that adequately incorporates the needs of the consumers and providers, as well as the unique demographics of the state was seen as the cause of "a wholesale deterioration in the range, depth, and quality of services in WV." From the provider point of view, the overcrowding issue at the State Hospitals is just the tip of the iceberg. In their opinion, it is a symptom of a bigger problem in the community system that is significantly limited in its ability to meet consumer needs. The fact that the State continues to spend millions of dollars annually on "Diversion" hospitals and not on community-based services designed to reduce admissions to the state system only further frustrates providers and widens the gap between them and State Officials.

As stated earlier in this report, the state has commissioned its share of consultant groups, reports, and expert feedback on the state of the state's system of care. From the provider's point of view, little if anything has changed and they expressed feeling as if they are adrift at sea with few supports from the state to adequately address their concerns. The expectation is that they do more with less and with fewer options on how to help their consumers survive and survive themselves. Most organizations report barely being able to meet expenses, and many indicated that they have struggled for several years on revenues, which have been less than costs.[39] Few organizations report being able to offer reasonable or any cost of living or other increases for the staff. Some have had to close or reduce facilities and many have had to reduce the professional level of some staff positions. Clearly there are historical, local, and other reasons why some of these organizations are managing less well than others, but even the most financially stable Comprehensives do not have much of a safety net.

d. What has your experience with APS been like?

Informants described a relationship with APS that has developed during the last decade. Initially, the experience might best be described as adversarial, especially as providers attempted to transition from an unrestricted pre-disallowance market place to that of a highly managed environment. For many, it was difficult to make the transition and effectively adjust to the administrative demands and costs associated with a new system of care, especially electronic medical records. Some Comprehensives were able to embrace these changes earlier and more successfully than others despite continuing complaints about documentation requirements and the inability to get authorization for what they consider to be "core" services. However, at the time of this report, most felt that they have adequately developed the expertise and experience to "play the game" and were able to effectively work with APS in a professional manner.

All those interviewed noted that APS is an efficient and well-run organization. A few actually acknowledged that it had improved their and the overall state's accountability. Even complaints regarding the amount of information that is still required, were recognized by at

[39] See cost sheet across state programs in Appendix 8.

least a few as a necessary evil since the state needed and used the data for alternative purposes (e.g., Block grants, etc.).

Still, most representatives from the Comprehensives were unanimous in their belief that APS has, at least indirectly, molded the system of care by an over restrictive and unnecessarily narrow interpretation of the already limited Medicaid codes and guidelines. Some were less vague claiming that APS's actions have been intentional. Regardless, this "ratcheting down" as some referred to it has had a dramatic effect, virtually eliminating the utilization of certain service codes in the community.

e. Describe and evaluate the authorization process.
f. What changes would make it better?

As noted above, the authorization of services has evolved into a rather unremarkable process. The Comprehensives report having become rather competent in meeting the demands and expectations of APS and the whole process is now somewhat uneventful. Much of that was attributed to the training and related technical assistance provided by APS in the past. However, despite continuing complaints regarding the inability to obtain authorization for certain "core" services, a more pressing issue were concerns regarding the impact of MCOs on the overall authorization process. An expectation for additional, as well as individualized information by MCO was very alarming. Some of the agencies have begun to modify their systems in preparation for the anticipated implementation, but without definitive guidelines and clear expectations they are frustrated. Recent negotiations have determined that APS will continue to administer the collection of assessment data and the tracking of authorizations, but agencies will still need to work with the MCOs around authorizations if and when the system goes into place.

g. What has been your experience with denials?

Prior to the structured interview process, CSM had been informed by APS that they have documented only about 200 denials since the inception of their oversight role. Although the Comprehensives generally confirmed their sense of a similar low number of denials over the years, they were quick to qualify their opinion. First, as previously reported, they had, through a trial and error process, "learned" what would be approved. They suggested that they had learned the lesson the "hard" way, especially following multiple retrospective reviews, which led to them having to pay money back to the state. When certain codes and services were routinely disallowed, they simply quit seeking authorization for them. Second, they also reported that APS frequently "encouraged" them to modify initial authorization requests. Typically these request included the reduction of service intensity and duration. Although not counted by APS as an official "denial," they clearly represent a reduction in services requested. As noted above, the Comprehensives have largely adjusted to the practice and now simply comply. However, some representatives did suggest that it might have been more beneficial to the system overall if they had proceeded with their original treatment requests. By being so readily compliant they have exempted APS from formally denying a greater volume of authorization requests potentially distorting an accurate assessment of the situation.

h. What codes and related services do you have concerns about in terms of availability, ability to utilize, etc?
i. What concerns do you have with documentations or other administrative processes with APS?

CSM experienced a virtual unanimous response from those interviewed regarding specific concerns and issues dealing with the current Medicaid codes for services. They reported what they termed a "systematic and calculated" protocol to remove from the system of care access to specific codes. As a result, targeted case management, personal care, day treatment, basic living skills, and behavior management codes are infrequently used across the state and in some areas not at all. Most attribute this to a combination of the current language in the Medicaid State Plan and the subsequent restrictive interpretations by APS. APS's denial of initial authorization, continued authorization, and the requirement for appropriate and comprehensive documentation (in the rare instances when these services were authorized) have all but eliminated the provision of these services. Along with historical concerns regarding current levels of reimbursement, most providers have been forced to abandon these services from their continuum of care, except in rare circumstances. The prospect of having to add additional fields of information to meet future demands imposed by the MCOs has also inflamed feelings and emotions within the community.

A lot of the energy surrounding this issue centers on the fact that the documentation requirements exceed the capacity of those bachelors level and lesser staff that provide the majority of these services. Unfortunately, the reimbursement levels are too low to allow agencies to upgrade the staff. Repeated trainings had been requested and provided by APS, but generally to no avail. A lone bright spot that was reported was a change in the reimbursement structure as well as other staffing-related changes for ACT programming. These changes have led to an increase in the number of applications for ACT teams across the state. Still, few of the Comprehensives located in the more rural parts of the state admit to being able to provide ACT services. A combination of the staffing requirements demanded by the model, barriers to transportation and the volume of appropriate clients have precluded them from implementing ACT Teams. These particular agencies did acknowledge the value of this type of programming and expressed a desire that the state explore the potential of ACT-lite services that would take into consideration the demographics and challenges of the rural environments.

j. Describe an ideal range and depth of services for those you serve.

As noted in response to several of the questions above, the Comprehensives largely feel that they do not have access to a continuum of care that is sufficient to effectively treat consumers in the community and to successfully keep those individuals out of the hospital. Particularly, the lack of access to acute services for those individuals with serious and persistent mental illness is identified as the most significant gap. Along with day treatment, targeted case management and basic living skills, access to adequate housing and residential services were repeatedly identified as services most needed. Additionally, greater access to a standardized CSU level of care including the capacity to manage a more acute care patient was also noted.

k. What has your experience been with BMS?

The most consistent response from the Comprehensives was that BMS is out of touch with their needs and the needs of their consumers while being more focused on the medical and/or physical health-related issues of Medicaid, which account for the largest share of dollars spent in the state. They expressed concerns that they have not been adequately engaged in providing information for planning or in the planning process overall. They felt that they were often blind-sided with changes that had significant impact on them and the consumers they serve. The former Mountain Choices' extended versus basic program option was often cited as an example of this lack of "connection" with the provider system. Before it was terminated, the program's confusion created extra work and (in their opinion) unnecessary financial strains.

Similarly, the proposed implantation of a managed system of care was repeatedly noted as another example of BMS implementing a major system change without sufficiently soliciting impact from the provider base, as well as the consumers they serve. All expressed concerns that this new system will be considerably more labor intensive, confusing to consumers and providers alike and ultimately result in diminished funding for critical services. Interviewees also doubted the program's capacity to meet its stated goal of integrating primary health care with behavioral healthcare delivery especially since two of the identified MCOs have already indicated that they would sub-contract behavioral health to another provider.

It should be noted that representatives from the Comprehensives support the concept of healthcare integration. However, they object to the idea of an outside entity further adding to the perceived confusion and documentation demands. Several of the Comprehensives already have active coordinating roles with local primary care providers doing this work at the grassroots levels. A number of places pointed out the SAMSHA focus on actually providing this integration within the behavioral healthcare organization.[40] In fact, one of the Comprehensives, Prestera, has received a SAMSHA grant to do this very thing. Again, the state's decision to move forward with a managed system of care further clarifies for them the lack of a coordinated effort and planning process designed to best serve the most vulnerable consumers in the system. Representatives from the Comprehensives do acknowledge that they understand the limitations being imposed upon BMS from within the state government but still feel that there could be more of a partnership and not so much of a top-down approach

l. What, if any, changes need to be made with regard to BMS and the programs it authorizes?

The majority of the Comprehensives expressed a belief that the state's response to the Medicaid Disallowance was and continues to be unnecessarily restrictive and borders on being punitive. Although they recognize that the pre-disallowance system was virtually "out

[40] *Co-locating Primary and Specialty Care in Community-Based Mental Health Settings (Sec. 5604)*. http://www.samhsa.gov/healthreform/docs/Co-locating_Primary_Care_Community_MH_508.pdf

of control," BMS has gone to the alternative extreme. As indicated above, they believe that directly and indirectly the range of service codes that were included in the revised state Medicaid plan and subsequent revisions have directly contributed to the deterioration of the system of care. In addition, APS's interpretation of these codes has further eroded the system by effectively eliminating access to selected services. Despite improvements in rates, as well as some greater flexibility for certain codes implemented following the "Agreed Order," access to what are considered "core" services is still very restrictive or non-existent. The fact that these essential services are those needed by the most highly-dysfunctional consumers is even more frustrating.

Perhaps of equal importance, is the failure of the state to adequately replace those funds removed from the budget during the "Medicaiding" of the system. Most of those interviewed recognized that Medicaid funding alone will never sufficiently fund a comprehensive system of care. Although somewhat mitigated by the three-year plan provided for in the Agreed Order, the loss of these funds has had a significant negative impact. In addition, delays in implementation and concerns about the availability of re-occurring funds to support these improvements to the infrastructure have created doubts and skepticism regarding their overall effectiveness.

Overall, the Comprehensives believe strongly that in order for the system to improve, including the ability of BMS and APS to effectively execute their respective roles and responsibilities, the state needs to facilitate a comprehensive planning process. Further, that planning process needs to engage the support and involvement of the providers to effectively meet the challenge of moving forward.

m. What are your impressions of the proposed MCO process?

At the conclusion of the interview process none of the 13 Comprehensives acknowledged that they had as yet signed a contract with any of the three MCOs. Although representatives from these agencies were all somewhat reserved with regards to any specific plans or negotiations they might be involved in, they all expressed a number of common concerns about this proposal. Clearly, one of their most immediate issues was the absence of any proposed UM guidelines or related specific operational information. They felt that it was absurd that they should be asked to contract with the MCOs without the opportunity to fully review these protocols.

Even without the opportunity to review the UM guidelines all respondents felt that the implementation of a managed system of care would minimally add another layer of unnecessary bureaucracy creating confusion for both consumers and providers. These demands, on top of what they already perceive to be unrealistic expectations from APS, would in their minds further limit their ability to effectively meet the needs of the consumer. Equally concerning was a fear that the MCOs, unlike APS, will have financial incentives, the end result of which will be further reductions in the provision of services and greater budgetary challenges for the Comprehensives.

Finally, as noted earlier in this discussion, most of those interviewed doubt that the program

will effectively meet the stated goal of integrating behavioral and primary healthcare. Two of the MCOs have already indicated that they would sub-contract the management of behavioral health services to another entity. That decision raises doubts in the minds of leadership from many of the Comprehensives as to the real intent of the program. In their opinion it is just another example of the state's lack of credibility and commitment to the needs of consumers in the community.

C. State Hospital

CSM met with and interviewed a number of staff members at both Sharpe and Bateman State Hospitals. CSM also visited and toured both facilities during the project. The primary goal of these activities was to gain insight into the role these facilities have in the overall system of care and to understand more fully the recent history of overcrowding, primarily at Sharpe Hospital. In addition, CSM was interested in following up on complaints from the community providers that their inability to obtain authorization from APS for certain service codes had a direct impact on the number of individuals being committed.

Feedback from those interviewed confirmed that both hospitals struggle to effectively discharge patients back to the community and that has had a direct impact on the census at both facilities. Limited access to residential options and transportation, especially in rural areas were cited as significant challenges. The inability to consistently arrange for the administration of injectable medications and other newer medications in the community was also identified as imposing a barrier to designing a successful discharge. When asked if they thought the providers concerns about access to care in the community were directly impacting census, those interviewed did not feel that they were qualified to make that connection. However, they clearly acknowledged that what they saw as an insufficient continuum of care in the community did contribute to the high recidivism rate of patients being discharged. Related to the providers concerns CSM was provided with a statistical chart showing a trend analysis of involuntary commitments from 2000 through 2006. Between 2001 (the first full year of APS's administration of the authorization process) and 2003 the number of commitments state wide increased nearly 220%. From 2003 to 2006 the number of commitments remained relatively constant. Data from 2006 to present was not available for review nor did CSM review other potential factors that might also have impacted the increase in commitments. However, the data as presented makes it understandable why the community provider system attaches such negative significance to the role APS has played.

Certainly a significant factor contributing to the over census issue, especially at Sharpe Hospital, is the growing number of forensic patients placed there through the judicial system. Ironically, CSM observed that on most days the total number of forensic patients at the two state hospitals is basically the same as the number of patients in diversion hospitals (see below). A further investigation of this coincidence might be helpful as part of any overall planning process but was considered to be outside the parameters of the current project.

D. Diversion Hospitals

In response to the overcrowding issue at the state hospitals, the state has instituted a "diversion

hospital" program. Patients requiring commitment for which no bed is available at the state level can now be admitted to series of acute care community hospitals located throughout the state. The use of diversion hospitals has reportedly increased over the years, especially as the capacity of the state hospitals system has been exceeded. At present an average of 100 patients a day receive care in a diversion hospital. By design or necessity, it has emerged as a significant component of the care delivery system in WV but not without a significant cost to the state. The program guarantees payment for those patients committed to the diversion hospitals if Medicaid and/or others payers are not available. An estimated 12 -14 million dollars was being paid to diversion hospitals at the time of this report. These dollars represent a particularly sore subject in the minds of most of the Comprehensives. Those interviewed largely contend that if BMS and APS collaborated to ensure greater access to certain services then many of these individuals could be successfully treated in the community. Minimally they expressed growing frustration with what they described as yet another example of the state's inability to effectively plan for the needs of consumers.

As part of this project, a limited number of diversion hospitals were visited. They have clearly responded to a need in the system, and one could legitimately argue that they provide a more "community-based" setting than the state hospitals. Indeed, the average length of stay for the majority of patients was reported to be less than that of the state hospitals. However, there were significant numbers of individuals in those facilities visited (and by report at others) that had been in the hospital for many months and some for over a year. Reasons for these extended stays were consistent with concerns identified by staff at the state hospitals, as well as those from the Comprehensives. Lack of adequate community services including housing with supports, CSU levels of care capable of managing more acute care needs, more intensive outpatient services (especially substance abuse, day treatment and ACT programs) and the absence of a comprehensive community medication formulary were noted. Additionally, staffing and other related resource limitations often prevents timely and in-person coordination by the Comprehensives to help plan for successful transition back into the community.

E. Advocacy Group Perspectives

The various advocacy groups interviewed by CSM reported similar concerns about the recent overcrowding issues at the state hospitals. They were also quite concerned about the quality and number of staff working at both facilities. Their comments regarding lack of residential placement options, access to transportation (especially in rural areas) and the availability of certain medications in the community echoed the concerns and observations of staff from both state hospitals and the Comprehensives.

It was also reported that patients admitted to a diversion hospital would not have access to new programming options being funded over the next three years through the Agreed Order. Advocates indicated that those programs, especially group homes, day treatment and supportive housing were exactly the types of services that this patient population could benefit from most. Denying them access to these necessary programs would likely extend their stay in a diversion hospital (also adding to the state's costs) and likely increase the possibility of re-hospitalization in a short time.

F. Consumer/Family Perspective

To effectively obtain the perspective of consumers and their families, a number of ideas were initially proposed and discussed with members of the "Project Management Team"[41] and the Court Monitor's Office. Ultimately, it was decided that attempting to survey this group was neither feasible nor warranted. It was decided that attendance at the annual meeting of the WV Mental Health Planning Council meeting in Charleston would be a more appropriate venue as well as more productive. A member of the CSM team attended the meeting on October 28, 2010. An added benefit to attending the meeting was the opportunity to hear the three designated MCOs make presentations on the range and scope of their future responsibilities. It also allowed CSM to hear first hand the reaction of those consumers/family members present. Following these presentations, CSM facilitated a confidential discussion with consumers/family members to solicit their opinions and specific concerns regarding the status of West Virginia's mental health system and to record any recommendations that might be relevant to this report.

A number of self-identified adult consumers, parents and family members of consumers (both adults and children) were present at the Council meeting noted above. During the MCO presentations, a number of these individuals expressed strong reactions to many of the ideas outlined by the MCOs. Consumers and their families expressed both disappointment and concern about what they perceived as another level of bureaucracy, which they felt would further dilute access to care. Many expressed confusion over the potential choices and plans while others doubted the ability of the MCO case managers to gain a confident and working knowledge of the state to effectively interact with consumers. Limited telephone access and other logistical issues were noted as challenges that would effectively reduce already diminished options and availability of services. Ultimately, many of those consumers/families in attendance expressed their fear that implementation of the MCOs would only reduce the amount of money available for services with no gain in quality and/or quantity of services delivered to the most vulnerable.

During CSM's personal time with representatives from those consumers/families attending the Council meeting, many of these same concerns were expressed. Additionally, there were repeated comments about the lack of housing options, especially for those needing more than modest supports to be successful. They were adamant that many individuals remained in the State Hospital and other hospitals long beyond a clinical need because of these shortages. The group also expressed concern for the lack of service options, the intensity of options, and the overall impact that limited transportation can have on their ability to attend programming. Although most were not familiar with specific names or service codes, they did mention the lack of case management services, which they indicated was more prevalent in the past. Transportation services, for example, including visits to the psychiatrist and other appointments, food shopping and visits to other government office meetings were mentioned. Face-to-face meetings with case managers to provide support and encouragement especially around medication compliance and other supports were likewise referred to.

Many expressed the need for more day program options particularly those designed to get consumers involved in activities, provide social outings to get them out of their homes and

[41] See Appendix 9 for a complete list of members.

active, to teach them basic living skills, etc. Most relayed memories of a time when these services were more common and expressed a feeling of loss that it was no longer the standard of care. The experience of others was that providers were becoming over-reliant on medications as a substitute for the loss of programming and that they were in some cases being over-medicating to ensure compliance. An almost unanimous comment was the demand for more peer support services. Many of these individuals had been involved in such services for many years and felt that they had been instrumental in helping them and others to maintain themselves in the community. Finally, although lacking a sophisticated understanding of the issues most felt that much of the change they have experienced was directly due to restrictions within the current funding mechanism. Concerns about the impact of the MCOs have only exacerbated their fear about the future.

G. Survey Results

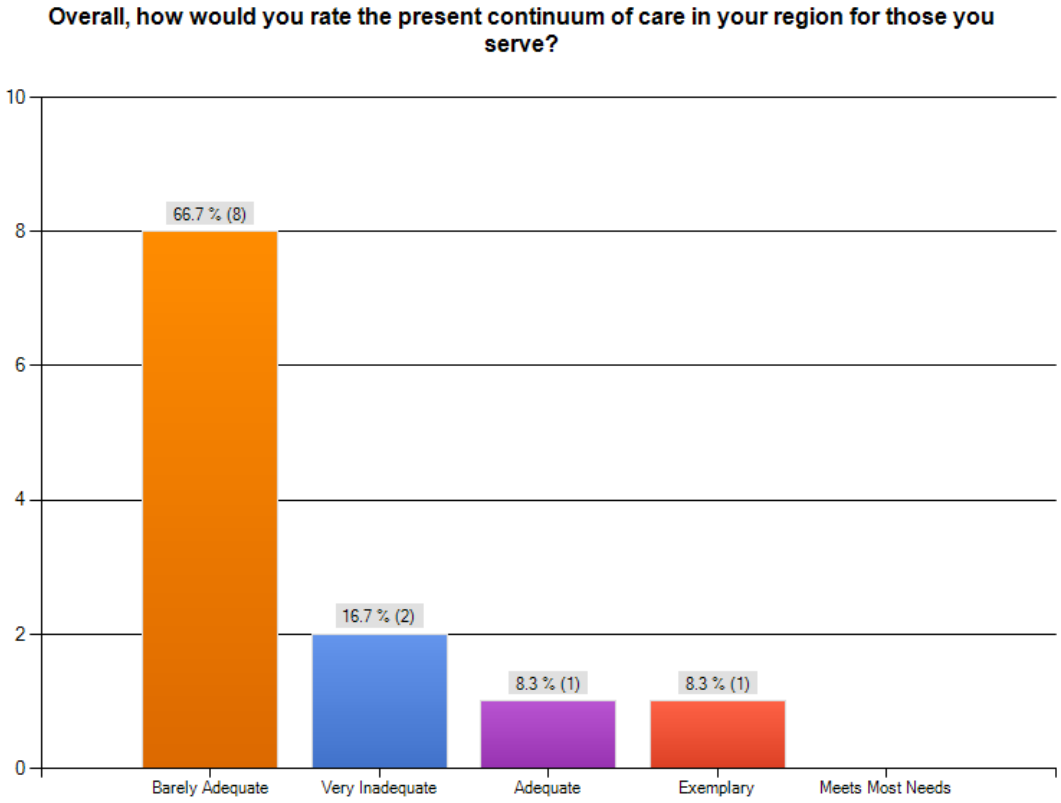
In addition to the formal interview process that was completed with representatives from the 13 Comprehensive agencies, a web-based survey questionnaire was also utilized. Although some overlap exists between the questions in both formats, the survey was designed using primarily Likert-type questions that allowed data from the survey to be formally analyzed and compared across the respondents. Those completing the survey were also encouraged to provide written narrative responses to individual questions for more detail and/or commentary. The Court Monitor's Office officially informed the Comprehensives by email advising them of the survey and the protocol for completion. CSM also informed the Comprehensives during the interview process.

The surveys were first sent to the CEOs of all 13 Comprehensives on December 3, 2010 via email containing a link to SurveyMonkey[42] for completion of the online, web-based survey tool. A subsequent email reminder was sent out on December 9, 2010. John Russell, Executive Director of the provider organization, also sent out an email encouraging all Comprehensives to respond on December 21, 2010. Additional email reminders were sent out in late December and the survey was closed on January 7, 2010. A total of 12 of the 13 Comprehensives completed the questionnaire.

The results by question are as follows:

1. Overall, how would you rate the present continuum of care in your region for those you serve?		
Answer Options	**Response Percent**	**Response Count**
Very Inadequate	16.7%	2
Barely Adequate	66.7%	8
Adequate	8.3%	1
Meets Most Needs	0.0%	0
Exemplary	8.3%	1
Please explain:		10
	answered question	**12**
	skipped question	**0**

[42] www.surveymonkey.com



Number	Response Text
1	The issue of substance abuse contributes to major gaps in helping people. There is a lack of strong TA and State direction that contributes to the lack of a strong continuum too.
2	Substance Abuse is one of the biggest issues in our area. There is a need from for more services for both men and women including everything from residential to outpatient programs. The vast majority of these consumers actually have a mental health diagnosis and, at least in the beginning, deny any substance abuse problems. Mercer, McDowell, and Wyoming counties actual have excellent low end and high end services. By low end, I mean Medication Management and availability of seeing a Psychiatrist. By High end, I mean that we have a local hospital with a Psychiatric Unit that accepts diversions. Southern Highlands also operates a CSU that serves both consumers with mental illness and/or substance abuse problems. We need more substance abuse outpatient programs and day programs for the chronically mentally ill.
3	The behavioral health system has suffered many cuts to programs and in some cases rates. The ability to continue to meet consumer needs depends on whether or not further restrictions or reductions are made. Service availability depends on presence of behavioral health provider especially in remote locations of state. This is being severely hampered by continued narrowing of medical necessity and documentation requirements for services that are provided.
4	It lacks the supports necessary (both residential, day, vocational, and case management) resources to care for the most severely and chronically ill.
5	18 Bed Inpatient Psych Program (integrated with Mental Health Center) 3 Crisis Stabilization Units/Programs (1 for MI; 1 for Addiction and 1 for Children) 3 Intensive Outpatient Programs (Addiction) Strong outpatient for both MI and Addiction 120 patient Assertive Community Treatment Program 24-Hour Crisis Services Mobile Crisis
6	This region lacks Crisis Stabilization services, psychiatric inpatient services, supportive housing

	for the mentally ill and day treatment services.
7	Huge gaps in the continuum of community services. No housing alternatives. No more day treatment services. Poor utilization of existing services (e.g., crisis stab services). No one in Charleston can see the big picture, let alone make decisions. No planning.
8	Services are available from various providers but there is very little coordination. Referrals are seldom made to the next lower level of care.
9	The continuum of care has many gaps in it, which renders it inadequate. We lack residential facilities for children and adolescents, and for substance abusing children and adults. There is shortage of psychiatrists in WV especially for children which ties our hands in being able to provide timely access to services. The rates are too low so we are unable to pay a competitive wage, therefore we have many job postings and waiting lists.
10	• Splintered services among different providers • Poor communication between primary, inpatient and out-patient providers • Funding streams force providers to compete for the same money • We believe that the continuum is improving Relationship between providers and State officials is poorly organized and often adversarial. There is a lack of coordinated planning among State and provider representatives in addressing care issues, with many mandates from the state inadequately funded. Coordination of care could be improved with increased provider involvement in multidisciplinary treatment planning, but this planning needs to be funded and logistically feasible (e.g., a case manager should be able to utilize televideo conferencing and bill for his or her time while participating in a cross-state meeting). Sustainability is very difficult to assure with so many providers attempting to access limited grant funds available and shrinking or non-increasing federal/state dollars for services Unfunded mandates have not decreased, but in fact have INCREASED. Rate increases are few and far between while costs continue to rise. We note that the Hartley Agreed Order will be helpful; however, delays in resources availability and lack of coordination with providers will not result in a rapid response

Commentary and Analysis: The results from this question largely mirrored the feedback obtained during the individual interviews. The majority of responses (83.4%) reported a less than adequate continuum of care within the state. There was one response indicating an adequate level and one exemplary. CSM was informed (during our interviews) of these pockets where programming and access to care was viewed as being above average compared to the majority of other areas within the state. Clearly these are exceptions and more likely due to a combination of historical, geographical, and perhaps individual management decisions by particular agencies and not formal differences in the system of care. As such, they are likely more susceptible to changes in the local environment. Consistent with the responses from the interview process, those completing the survey identified a lack of services for those with co-occurring problems, poor planning and communication at the state level, the absence or non-access to certain key service options, geographic obstacles, and other problems.

2. List the types of programs/services that you feel are not available or sufficiently available to meet the needs of the consumers you serve:	
Answer Options	**Response Count**
	11
answered question	**11**
skipped question	**1**

Number	Response Text
1	The biggest gap is in housing and also flexible funding to design supports for primarily people with co-occurring disorders or straight SA issues. There also is a large training gap as each Provider has to address this on its own. Another issue is sound consistent aftercare and discharge planning for people who leave inpatient facilities.
2	In an ideal world, we would have more CSU beds that could be used to detox consumers. Once they are detoxed they could either attend intensive outpatient programs and/or residential programs. One of the biggest problems with intensive outpatient programs is there is still the need for some form of case management or care coordination to insure that consumer keeps appointments, etc. Target Case Management cannot be billed through Medicaid for this, Care Coordination is used in other ways, and there is nothing else. The other problem is that most male substance abuse consumers are self-pay and do not have Medicaid. There is more demand than we can handle for the Care Coordination program. This will assist consumers who are living in their own homes.
3	The region does not have an inpatient psychiatric unit or a CRU to provide services to consumers requiring this level of care. Otherwise, the array of services is sufficient; however, the limits (# of units) on service delivery can make it difficult to meet the needs of consumers. Any further restriction on medical necessity or reduction of units would make it impossible to maintain consumers in an outpatient setting.
4	• Women's substance abuse • Children's services
5	• group homes • in home supports • comprehensive case management • more extensive day programs • vocational training
6	• direct service CM would be valuable. consumers require more direct assistance than they are permitted under TCM model • mental health day program and group homes and more flexible crisis stabilization services (those not so tied to specific rules that tie the hands of providers) could result in few hospitalizations
7	• Inpatient Children • ID Crisis
8	• Crisis Stabilization services • Psychiatric inpatient services • Supportive Housing services • Day treatment for the mentally ill • Women's SA Residential program • Case management • Care coordination is an excellent program which the Bureau spearheaded. We are hopeful that the care coordination will do.
9	See above. Add traditional case management, lack of SA services, WV does not have public transportation in approximately 50 of 55 counties. BMS thinks they are solely responsible for controlling State expenditures. No one seems to be aware that about 80% of Medicaid services are paid by the Feds. No vision. Plenty of excuses.
10	• Detox • 28 day addiction rehab program • Crisis Stabilization Unit
11	Psychiatry, children's residential, substance abuse residential

Commentary and Analysis: The responses to this question provided continuing support for ideas and concerns identified during the interview process. Additional substance abuse services

(across levels of intensity), better access to local inpatient and CSU programs for more acute individuals, residential services and related housing options, greater access to day treatment services and other outpatient services, transportation, and comprehensive case management and care coordination services were noted. Respondents also echoed concerns regarding the existing range and scope of services and related access issues.

3. To what extent are the range of available Medicaid service codes (as set by the Bureau of Medical Services (BMS) adequate to address the needs of the consumers you serve?

Answer Options	Response Percent	Response Count
To a very small extent or not at all	0.0%	0
To a small extent	25.0%	3
Somewhat	50.0%	6
To a great extent	16.7%	2
To a very great extent	8.3%	1
Other (please specify)		9
	answered question	**12**
	skipped question	**0**

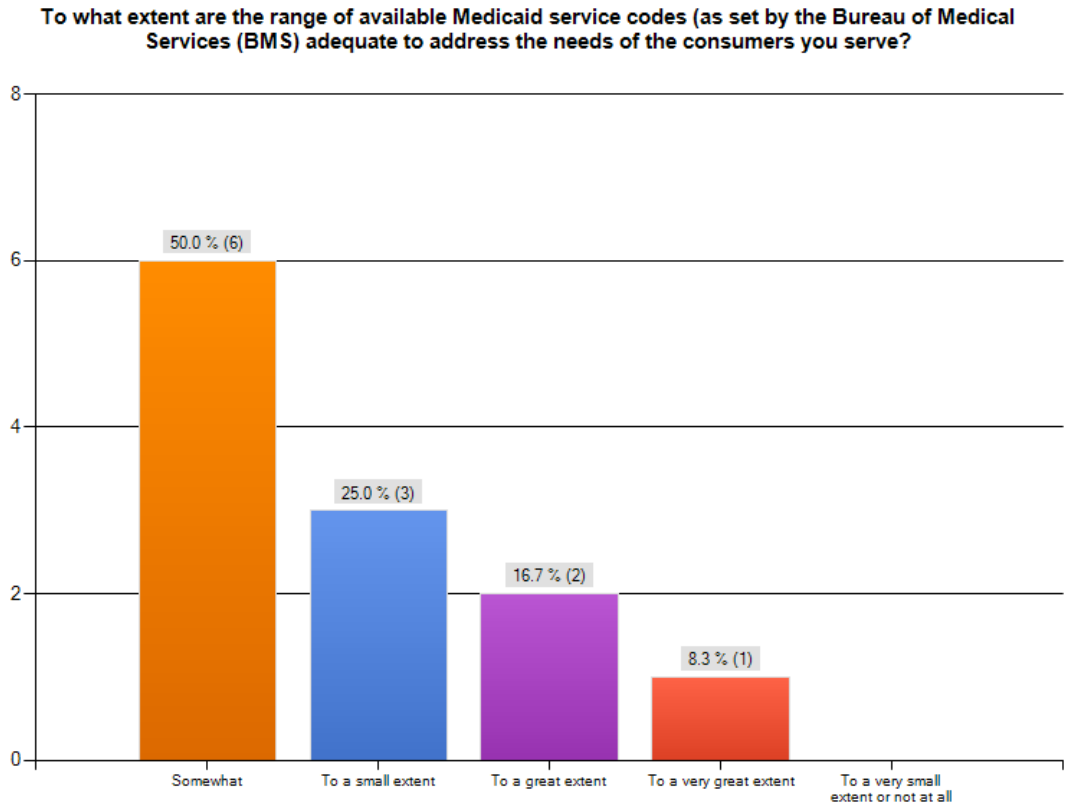
Number	Other (please specify)
1	Basic living skills and case management services are non-existent. We also need codes that can give us more options for people such as peer support and residential support.
2	The Medicaid codes are based on a medical model and what is needed are more support services for Medicaid consumers. The other issue is that more programs are needed for those consumers who do not qualify for Medicaid
3	The range of services is sufficient. The reimbursement rate, frequency of visits and narrowing of medical necessity criteria is hampering centers ability to meet consumer needs in the community based setting.
4	The BMS codes meet certain acute and moderate needs based on medical necessity but do not meet the other needs consumers may have. These other needs are better addressed by the codes available through the BHHFs additional codes and definitions. More availability of funds for the BHHF codes and core services support would help stabilize the community system

5	• We are torn between "to a small extent" and "somewhat
	• Comments:
	  • Pretty adequate. some additional SA, family and combined behavioral health/physical health services would be beneficial
	  • we are in need of residential per-diem services
	  • while the range is fairly broad, credentialing requirements are specific to each code, which results in a complex credentialing/privileging/competency system

6	As currently configured. Rates could always be better, but recent changes have helped, particularly with ACT. I certainly would not favor any reduction in rates or utilization. MCO initiatives could seriously threaten both.
7	• MI day treatment codes and basic living skills are difficult to get authorized. Nursing codes are needed. • There is a need for per diem codes for CSU services and ACT services.
8	While the available codes
9	• The Medicaid codes really leave out the MR/DD population. If a MRDD client isn't a

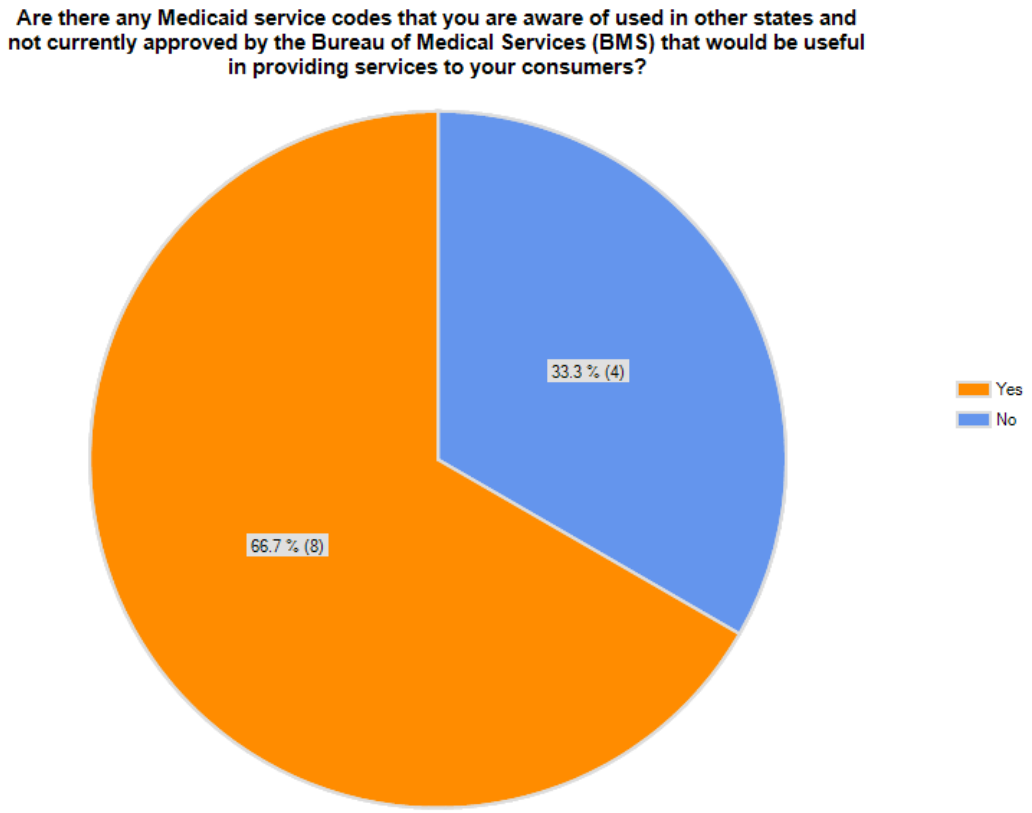
Waiver client the options are few and far between.

- Day treatment is too restrictive and not usable by the general MH population. Comprehensive psychological and psychiatric evaluation codes do not pay enough to cover the cost of the service. We lose each time we provide the service.
- There aren't any codes for nursing. Our nurses provide a valuable service and to say that the physician's codes cover their time too is ridiculous. The physician codes don't even cover the physicians.



Commentary and Analysis: A significant majority (75.0%) of respondents did not feel that there were an adequate number of available Medicaid service codes to effectively serve the needs of their consumers. This finding strongly supports the feedback from the interview process and is further validated by the state-to-state comparison completed as part of this project.

4. Are there any Medicaid service codes that you are aware of used in other states and not currently approved by the Bureau of Medical Services (BMS) that would be useful in providing services to your consumers?		
Answer Options	**Response Percent**	**Response Count**
Yes	66.7%	8
No	33.3%	4
If yes, what are these codes or services?		8
	answered question	**12**
	skipped question	**0**



Number	If yes, what are these codes or services?
1	See above
2	Basic Living Skills
3	Rural ACT would be much more useful in rural areas than the urban model currently being authorized.
4	There are many Medicaid services listed on the NAMI "Grading the States" report that are either not provided in WV, or are substantially less available than in other states. This includes, but is not limited to, such services as targeted case management, mobile crisis services, peer specialist, supported housing, supported employment, telemedicine, etc. While WV may have codes for some of these services, the regulations and utilization guidelines are too restrictive for them to be useful.

5	• Many others, including, but not limited to:
	  ○ 96102 and 96103-- psych testing
	  ○ 96150--96155 -- health and behavior services (behavioral health + medical condition)
	  ○ H2036 -- alcohol and drug treatment per diem
	  ○ H0001 -- alcohol and drug assessment
	  ○ H0015 -- alcohol and drug IOP
	  ○ 90849 -- multiple family group

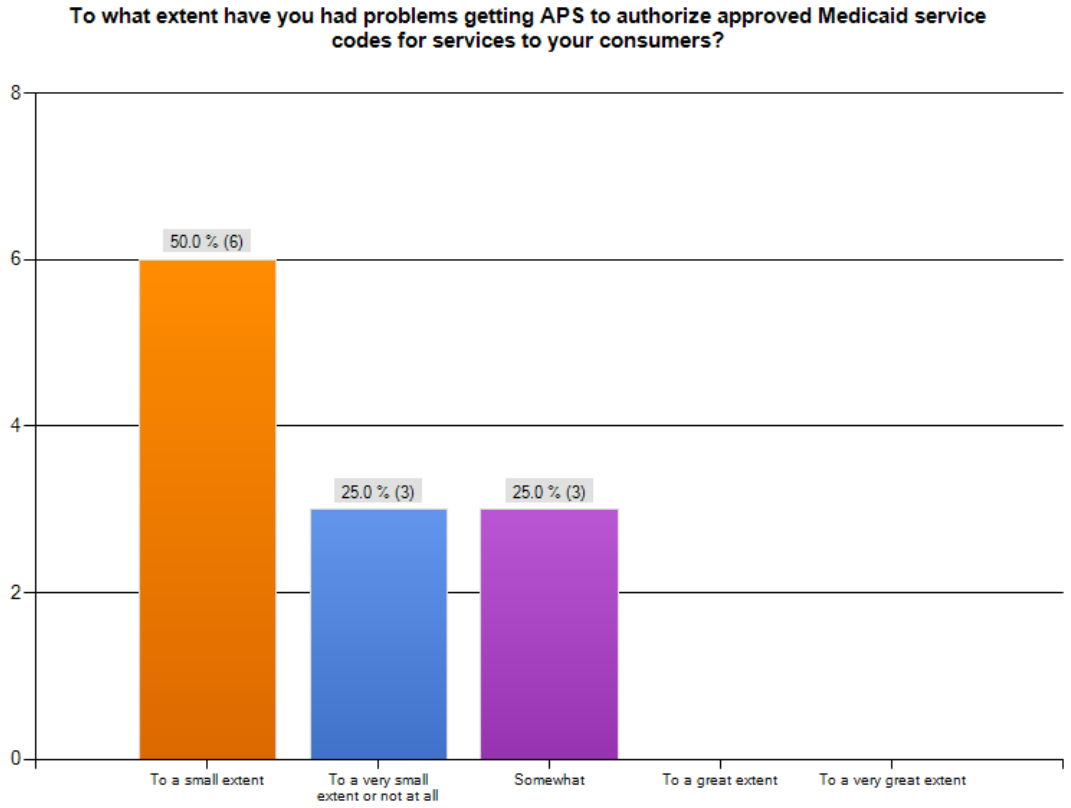
6	• Group Home care • ID Crisis

7	Other states allow for per diem codes for psychiatric services.
8	I am not aware of specific codes, but it is my understanding that CMS allows many other states to pay for a much greater array of services, including a lot of those that WV BMS says are not "medically necessary".

Commentary and Analysis: Responses to this question further clarified that providers in West Virginia have access to a smaller range of service codes than other states. This was a repeated theme throughout the interview process and confirmed in the state-to-state comparison completed by CSM.

5. To what extent have you had problems getting APS to authorize approved Medicaid service codes for services to your consumers?

Answer Options	Response Percent	Response Count
To a very small extent or not at all	25.0%	3
To a small extent	50.0%	6
Somewhat	25.0%	3
To a great extent	0.0%	0
To a very great extent	0.0%	0
Please provide details on specific codes or services and related issues:		9
	answered question	**12**
	skipped question	**0**



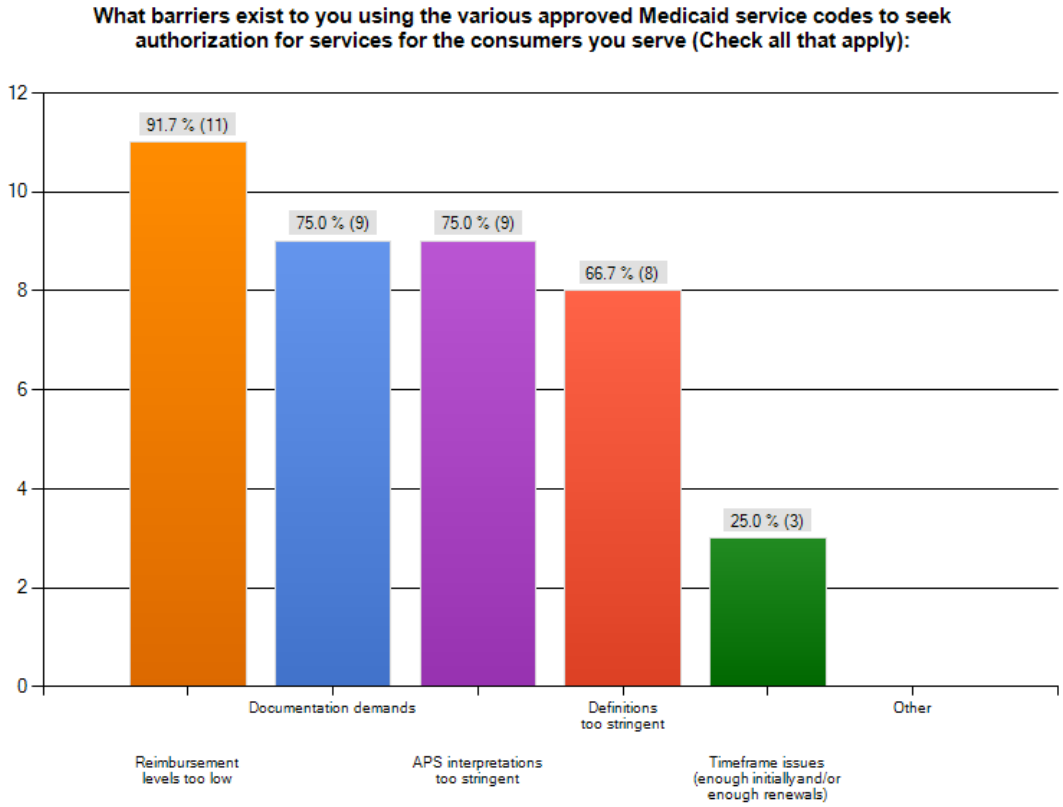
Number	Response Text
1	We have basically given up on TCM Basic living skills, behavioral supports and some day treatment. APS has made the window of how to do these successfully so small it is easy to give up. Remember the staff we have are BA level and some MA. The turnover is so great that this level of staff will never get in time.
2	The narrowing interpretation of medical necessity is a concern - particularly for psychological services which are provided at the request of a physician. The requests for additional units of therapy (individual and group) for consumers involved in Medication Assisted Treatment - Suboxone has been difficult.
3	Close work with APS and constant monitoring of claims by the Center has made the prior authorizations process more efficient and effective.
4	APS has dramatically reduced authorizations for basic living skills development and support, day treatment, and targeted case management.
5	No comment
6	Most of the problems have been on our end, however, there are times that circumstances favorable for treatment are overlooked, but generally APS is fair.
7	Level of functionality is set too low for some services to be authorized.
8	We are routinely asked to provide services to Medicaid recipients who are currently residing in the local regional jail, nursing homes and emergency youth shelters. These services are consistently denied by APS. Because these individuals have Medicaid, they are not eligible for Charity Care services funded by BHHF. Therefore, we have no means of reimbursement.
9	There are not specific codes that we have difficulty getting approval for. The issue is a difference of opinion between APS and the professional staff providing (or wanting) the service as to the medical necessity of that service of the frequency of the service.

Commentary and Analysis: On first review it would appear that the majority of Comprehensives do not have a significant problem obtaining authorization from APS for the provision of services. And yet, feedback in the comment section is more consistent with the experiences outlined during the interview process. Although there continues to be some resistance from APS to approve certain service codes, especially regarding medical necessity, at this point in time, there is often few obstacles for the majority of request submitted. However, that appears to be more a reflection of the fact that the Comprehensives have either reduced or largely eliminated certain service codes from consideration. As identified in the interview process, the providers have learned through experience which codes will be approved and which will not. For many that lesson appears to have been learned the hard way through repeated denials and/or retrospective paybacks. A review of utilization data from APS confirms the virtual elimination of a number of service codes from the system of care.

6. What barriers exist to you using the various approved Medicaid service codes to seek authorization for services for the consumers you serve (Check all that apply):

Answer Options	Response Percent	Response Count
Documentation demands	75.0%	9
Timeframe issues (enough initially and/or enough renewals)	25.0%	3
Definitions too stringent	66.7%	8
APS interpretations too stringent	75.0%	9
Reimbursement levels too low	91.7%	11
Other	0.0%	0
Other (please specify) or add other comments:		5
	answered question	**12**
	skipped question	**0**

1	Basic Living Skills and Targeted Case Management are both available services under WV Medicaid. The interpretation is so stringent that any review that we had showed that the services did not meet the guidelines. In the end, we stopped billing both codes.
2	• The documentation demands are compounded by multiple sets of requirements that do not always match i.e. Licensing, Medicaid, Medicare, APS and XIX Waiver, BHHF, BCF and BMS. This does not include the Third Party and Private Insurance requirements which compound the complexity for individual agencies. • Stringent interpretation is of less concern than having consistent interpretation to allow for Center staff to be trained in uniform documentation to meet multiple expectations. • Reimbursement levels included not just rates but number of units needed to meet individual consumer needs. Both need review and consideration. How units are measured (i.e., 15 minute units) also complicates documentation and billing.
3	• we believe that intensive services (IOP/CSU) would be better if authorized on a per diem basis rather than 15 minute fee for service • we stay away from certain services: TCM, Treatment planning required services, basic living skills because of inherent documentation and staff demands
4	The care connection forms are extremely cumbersome since July 1.
5	While the available codes may be adequate, the very restrictive interpretation of some codes is problematic. For example: Discussing child disciplinary strategies in Family Therapy being interpreted as "parenting" (thus disallowed) instead of Behavioral Family Therapy.

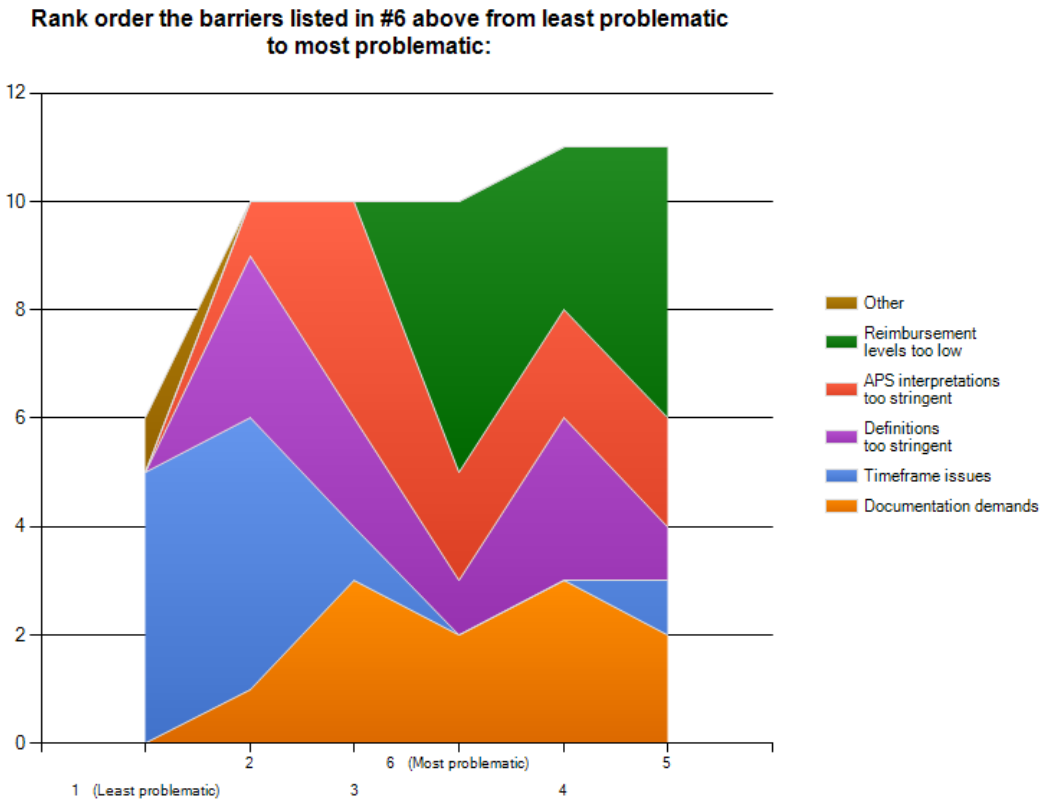


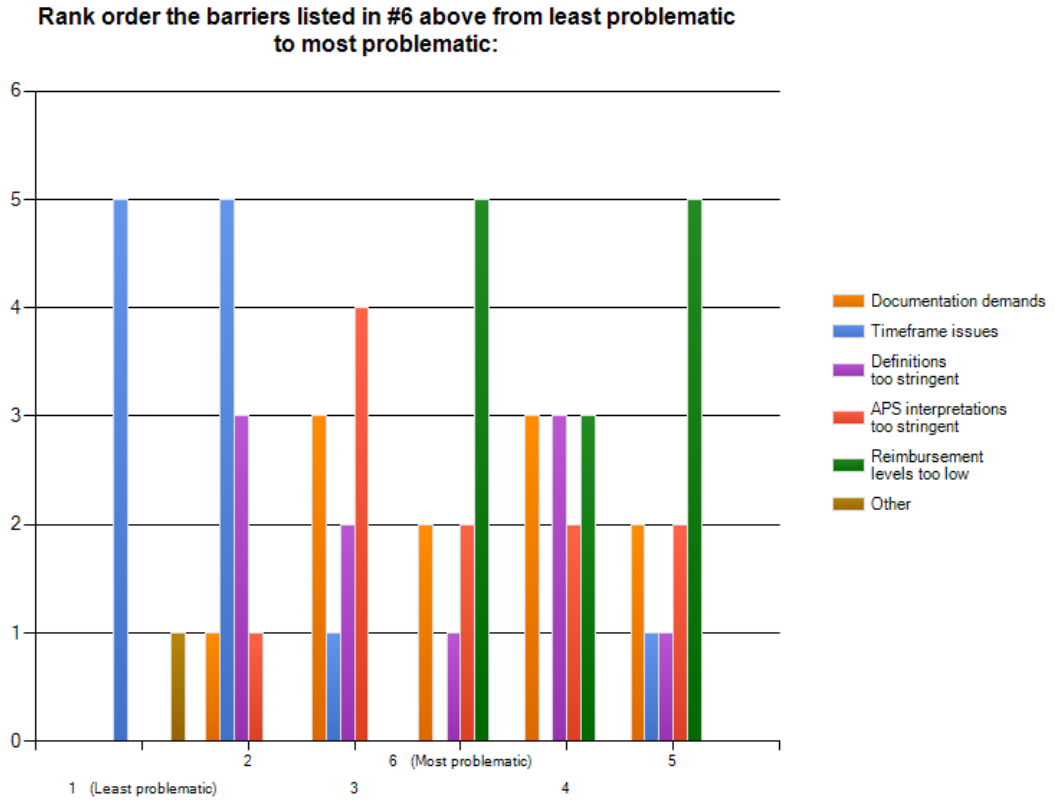
Commentary and Analysis: The barriers identified in the survey were consistent with feedback received in the previous interviews. The narrative section for this question provided some

additional details, but again these comments largely followed the responses solicited during the earlier interview process.

7. Rank order the barriers listed in #6 above from least problematic to most problematic:

Answer Options	Doc. demands	Time-frame issues	Definitions too stringent	APS interpre-tations too stringent	Reimbur-sement levels too low	Other	Response Count
1 Least problem)	0	5	0	0	0	1	6
2	1	5	3	1	0	0	10
3	3	1	2	4	0	0	10
4	3	0	3	2	3	0	11
5	2	1	1	2	5	0	11
6 (Most problem)	2	0	1	2	5	0	10
Comments:						4	
			answered question				**12**
			skipped question				**0**





Number	Comments:
1	APS interpretations and documentation demands may go hand-in-hand.
2	The rankings are flexible contingent upon who you are reporting to and about what you are reporting.
3	• rates too low • interpretations are inconsistent • interpretations are unclear
4	There is no methodology in place to establish and adjust rates based upon the expense of providing these services. This leads to it being always difficult to hire and retain competent, qualified staff. However, given the requirements for standard of care and quality of documentation established and enforced by BMS and APS, one would believe that all of our clinical staff were doctoral level and in the top 10% of their class! We are fortunate when we can find an applicant that meets the minimum requirements and no amount of training will ever overcome their limitations. When we are fortunate enough to hire competent, well trained clinicians, we tend to act as a training program before they are then hired by the school system, local hospitals or APS for a 25 to 50 percent increase in salary.

Commentary and Analysis: Responses to this question were very consistent with feedback received in a variety of settings during this project. Specific concerns regarding the financial and educational challenges associated with the hiring and retention of competent staff was a constant

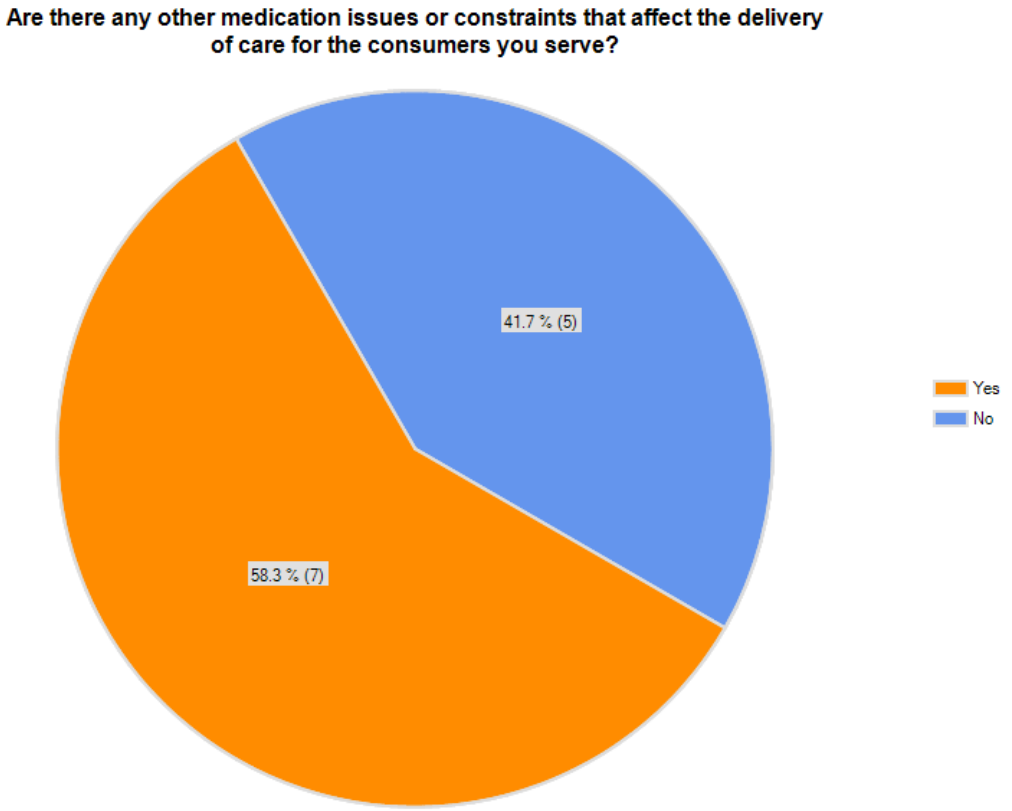
factor expressed by leadership from the Comprehensives, especially related to the documentation demands established by BMS and APS.

8. To what extent do you feel that the outpatient medication formulary (i.e., the Rational Drug Therapy Program for Medicaid) is insufficient to care for the consumers you serve?		
Answer Options	**Response Percent**	**Response Count**
To a very small extent	25.0%	3
To a small extent	16.7%	2
Somewhat	41.7%	5
To a great extent	16.7%	2
To a very great extent	0.0%	0
Please identify any specific concerns:		7
	answered question	**12**
	skipped question	**0**

Number	**Please identify any specific concerns:**
1	Many of the more common medications used in behavioral health are not on the formulary. The result is that there are many high paid doctor hours working with Medicaid and pharmacies to get authorization. Many times only the doctor can answer the questions. In our case, the consumers do get the medications but it is another cost to the Center who pays the doctor for this instead of seeing consumers.
2	We do employ nurses to assist medical providers with prior authorization and ensure the consumers actually get the medication ordered by the physician; however, it is at a great expense.
3	• New medications that are brand name may need to be included for consumers who have not had success on either other brand name drugs or on generic drugs. • At times hospitals release consumers on medications that they cannot afford or are not on the current formulary.
4	• We are torn between both "to a very small extent" and "to a great extent" • formulary is acceptable for Medicaid consumers • formulary is unacceptable for uninsured
5	Sometimes, the more expensive drug is by far the best. I understand the value of generics, but for pure clinical efficacy the formulary is somewhat restrictive.
6	Consumers with basic Medicaid have a very limited array of medications available.
7	Critically ill individuals may be stabilized in hospital settings with specific medications; however, upon discharge, Medicaid will not pay for the medication that proved effective.

Commentary and Analysis: This question was specifically added to the survey following feedback during the interview process. Limitations with the existing formulary are clearly a barrier to successful community-based treatment. State hospital staff indicated that often patients are stabilized and discharged on a medication regime that is not available to them in the community. In addition, related costs associated with the prescription and administration of some medications is not a covered costs, further burdening provider agencies that employ staff to assist consumers. For consumers who lack any insurance benefit or other financial resource, this issue is even more challenging often resulting in them not being effectively treated.

9. Are there any other medication issues or constraints that affect the delivery of care for the consumers you serve?		
Answer Options	**Response Percent**	**Response Count**
Yes	58.3%	7
No	41.7%	5
If yes, what are the issues or constraints?		8
	answered question	**12**
	skipped question	**0**



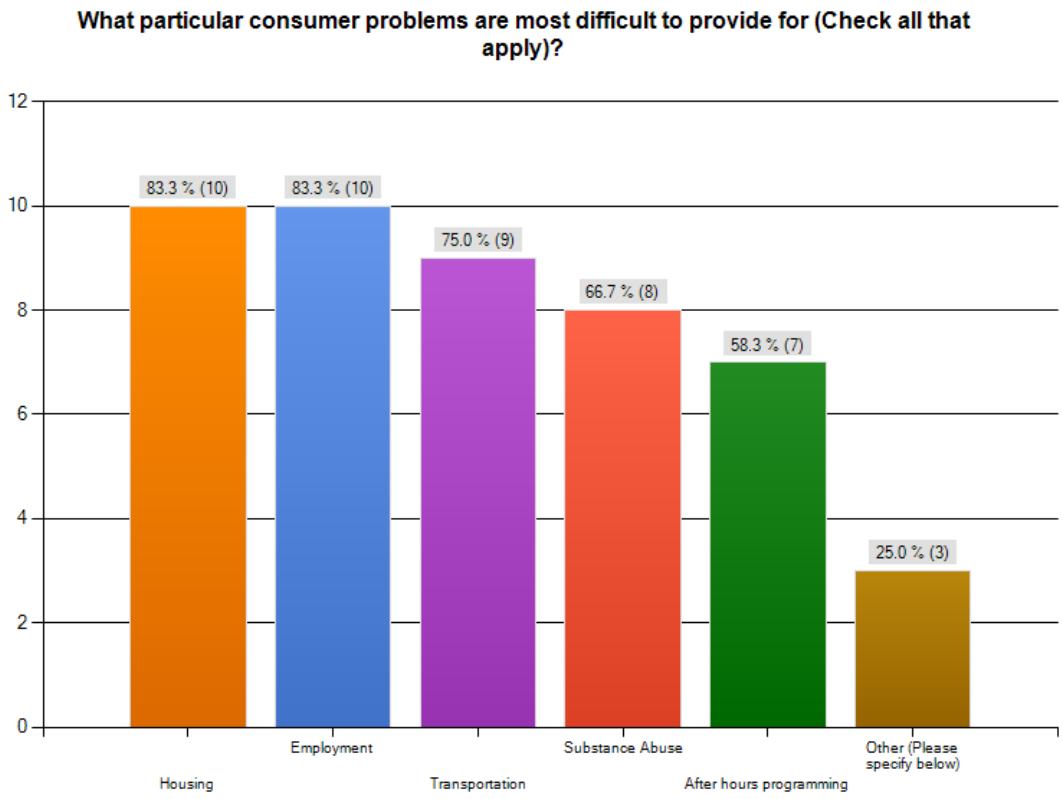
Number	If yes, what are the issues or constraints?
1	Funding for meds for people who do not have Medicaid
2	However, as stated above it is a considerable expense to deal with prior authorization issues. The rate for medical providers is not sufficient to offset the expense.
3	Some meds are not available at the pharmacy that we have to purchase and then get reimbursed by Medicaid
4	It is difficult to pay for the physicians time necessary to monitor the medications as required by regulations due to the current rates of reimbursement and the extensive documentation required to maintain accurate clinical records.

5	• committed individuals have only a few pills at discharge and agencies are required to assure that a continuation prescription is gotten in a short time • committed individuals leave with expensive medications and agencies do not have funds to pay for them • obtaining front line meds for uninsured individuals • struggling with justifying front line meds for insured individuals
6	• Coordination of drug therapy from Primary Care MDs and Mental Health • Coordination of drug regimes from State Hospital to Mental Health
7	Many of our consumers require close monitoring of their medications. They may not be capable of managing a month's prescription. However, Medicaid requires that they pay a dispensing fee that makes it impossible to have their medications prescribed weekly or twice/month. There is no adequate reimbursement to hire nurses to administer medications in the community.
8	There is no reimbursement mechanism for nurses doing the work around patient assistance and authorizations.

Commentary and Analysis: The comment section for this question more clearly outlines the on-going barriers to successfully managing the medication needs of consumers in the community. Again, the related costs associated with the prescription, dispensing and monitoring of medications is a significant problem, especially the limited or non-existent reimbursement available to directly assist patients.

10. What particular consumer problems are most difficult to provide for (Check all that apply)?

Answer Options	**Response Percent**	**Response Count**
Housing	83.3%	10
Transportation	75.0%	9
Employment	83.3%	10
Substance Abuse	66.7%	8
After hours programming	58.3%	7
Other (Please specify below)	25.0%	3
Other (please specify)		4
	answered question	**12**
	skipped question	**0**



Number	Other (please specify)
1	Peer support
2	Inpatient care/crisis stabilization services
3	Non treatment (medically necessary as defined by BMS) support services
4	Community based services such as day treatment, socialization, basic living skills, etc.

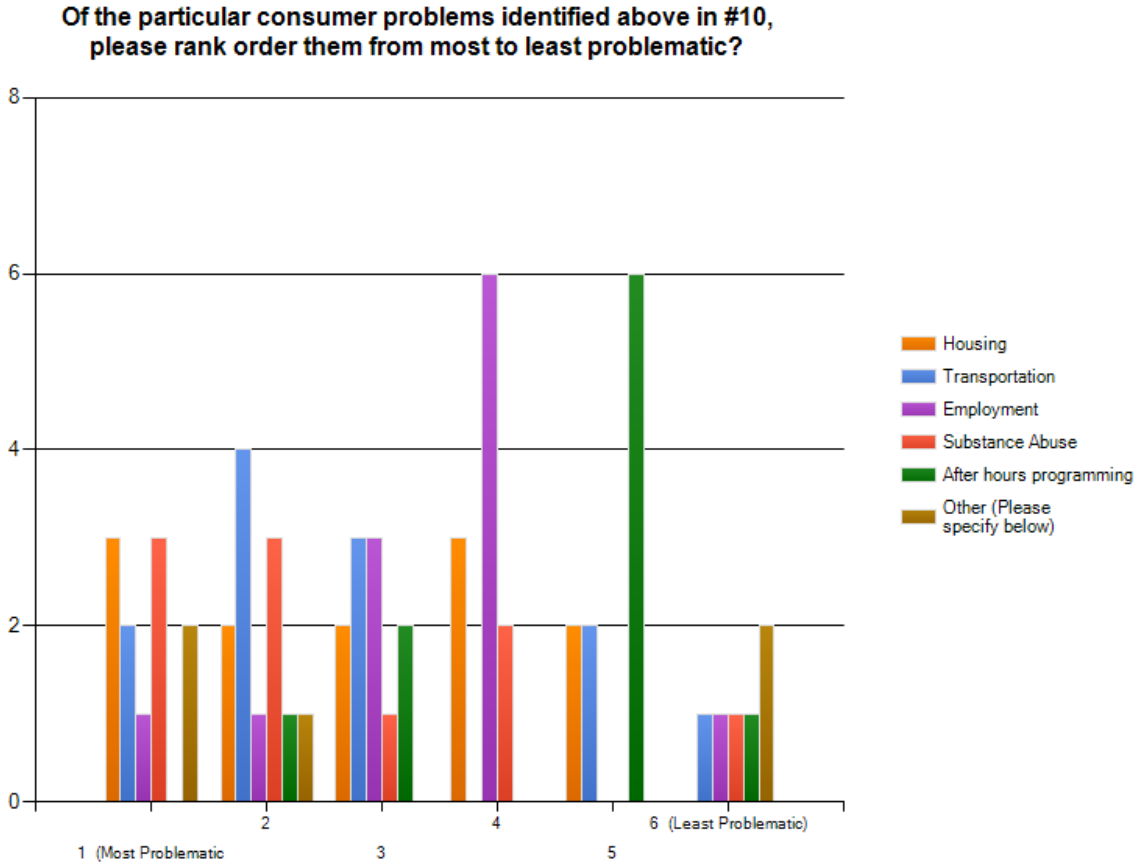
Commentary and Analysis: Housing, employment, transportation, and substance abuse problems were again identified as the most difficult consumer needs that the providers attempt to deal with. The need for after-hours programming was also frequently mentioned. Responses to this question closely aligned with the feedback from other sources and further quantified existing voids in the current system of care.

11. Of the particular consumer problems identified above in #10, please rank order them from most to least problematic?

Answer Options	Housing	Transpor-tation	Employ-ment	Substance Abuse	After hours program-ming	Other (Please specify below)	Response Count
1 (Most Problem)	3	2	1	3	0	2	11
2	2	4	1	3	1	1	12
3	2	3	3	1	2	0	11

4	3	0	6	2	0	0	11
5	2	2	0	0	6	0	10
6 (Least Problem)	0	1	1	1	1	2	6
Other (please specify)				4			
			answered question				**12**
			skipped question				**0**

Number	Other (please specify)
1	• Limited children and women substance abuse funding. • Limited public transportation for rural consumers. • Poor Job market and highest unemployment rates in some of the country served.
2	• Torn between answers above • we noted that for transportation, the more rural areas have a greater need • we note that for SA, inpatient beds are in short supply
3	Non-treatment (medically necessary, as defined by BMS) support services and traditional case management services provided by a minimum of bachelor's level trained staff.
4	Community based programs such as day treatment. Socialization programs. Programs teaching basic living skills.



Commentary and Analysis: This question relates to the preceding question and provides some additional sense of the problem facing community providers attempting to meet the needs of consumers. Housing, substance abuse, and transportation were regularly rated as more problematic than employment even though access to employment opportunities remains a constant challenge. Although not directly related to this project, specific women and programs for children were also mentioned.

12. What other changes to the system will allow you to better serve your consumers?

Answer Options	Response Count
	9
answered question	**9**
skipped question	**3**

Number	Response Text
1	There needs to be better leadership, training and support from the State.. We all need to be accountable. BHHF also funds programs in our region that we know little about so there is no coordination. There is no focal point of accountability at the State. BMS and BHHF do not have common goals. The Secretary of DHHR (former) is no help but a hindrance
2	• There are two changes needed in the WV Behavioral Health. The first is that there needs to be stability. I understand that things cannot and should not stay the same but the system has been jerked around for at least the last 5 years. The majority of the changes are not well thought out and many times have been reversed. This creates havoc with companies attempting to provide services but is even worse for consumers. • The second and most important change needed is a WV Behavioral Health plan or at least a road map of where we are going and plan to get there. It needs to be evaluated on a regular basis and changed as needed. Everyone needs to know what the plan is. Even if do not agree with the plan then we can still plan for our area.
3	Eliminating any further reduction in service units (therapy) and medical necessity interpretation will ensure that consumers are maintained in the community setting. Streamlining credentialing will reduce administrative cost of service provision. Reimbursement rate increase will ensure that services continue to be available even in remote areas of the state.
4	The current system has evolved and is working including the APS process and the Molina billing process. The behavioral health system is highly regulated and is functioning efficiently and to shift Medicaid from singe point to multiple point (MCOS) appears to be a step backward for the Centers and a giant leap for primary care providers to try to catch up with a truly functioning system. West Virginia has a system that has worked and has been reviewed for replication. Now it is being considered for disassembly and the primary care model integration system through MCOs is far less efficient than the current system. Simple math shows where multiple administrative cost are incurred either cost are increased or services are required or both. This change needs serious consideration. Not just statistical approximation. We are dealing with consumers' lives not just numbers.
5	We need to have a more robust continuum of care for individuals with chronic and persistent mental illness. These individuals often do not improve at the pace required by APS for continued authorization of services. Specifically, we need residential programs, in home support programs, day treatment programs, and more intensive case management. We also

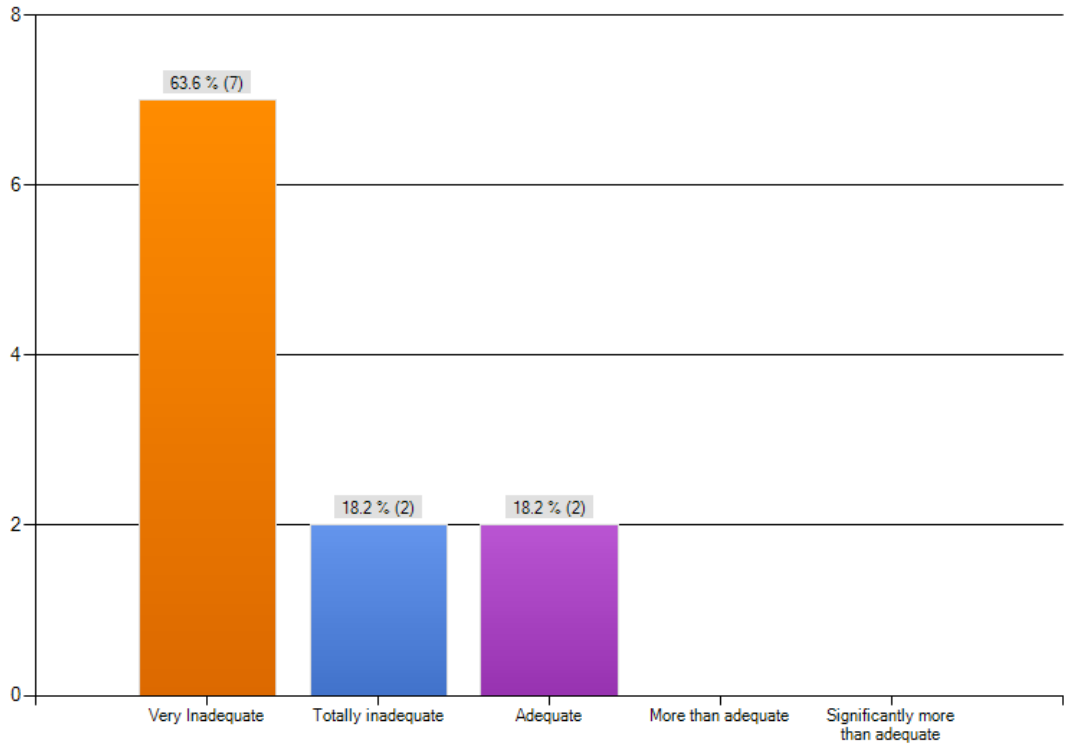
	need additional programs for individuals diagnosed with substance abuse problems.
6	None
	• A State Plan for a Behavioral Health System with standards, monitoring and rewarding for excellence has never been attempted.. The Crossroads Report completed by Providers needs to be adopted and worked toward. The essence of the report is the development of a specific continuum of Behavioral Healthcare services over regions within one hour of all WV residents. • Distribute uncompensated care dollars on a fee for service basis rather than continue the historical distribution method (politics) which does not demand service delivery for
7	funding, but encourages low creativity and productivity.
8	Develop or adopt a plan (could begin with the Crossroads Report) and display leadership skills to involve all parties to implement the plan.
9	De-regulation. The cost of compliance is driving our overhead costs up and is making it near impossible to give wage increases to our staff on a regular basis. We haven't been able to give an across the board increase in over 3 years. This affects recruitment and retention.

Commentary and Analysis: Nine of the 12 responders provided additional narrative information on needed changes in the system and their responses were consistent with the feedback obtained during the earlier interview process. Without question the majority of respondents identified the absence of a well-conceived, current, and comprehensive state mental health plan as a significant problem. This criticism was echoed by multiple individuals and groups throughout this project. In addition, related concerns about the qualifications of state leadership and a lack of "inclusion" were repeatedly raised by providers and others as major deficiencies in the existing system.

13. Overall, how adequate is the Medicaid reimbursement rate for the services you provide?

Answer Options	**Response Percent**	**Response Count**
Totally inadequate	18.2%	2
Very Inadequate	63.6%	7
Adequate	18.2%	2
More than adequate	0.0%	0
Significantly more than adequate	0.0%	0
Please be specific on any positive or negative reimbursements		11
	answered question	**11**
	skipped question	**1**

Overall, how adequate is the Medicaid reimbursement rate for the services you provide?



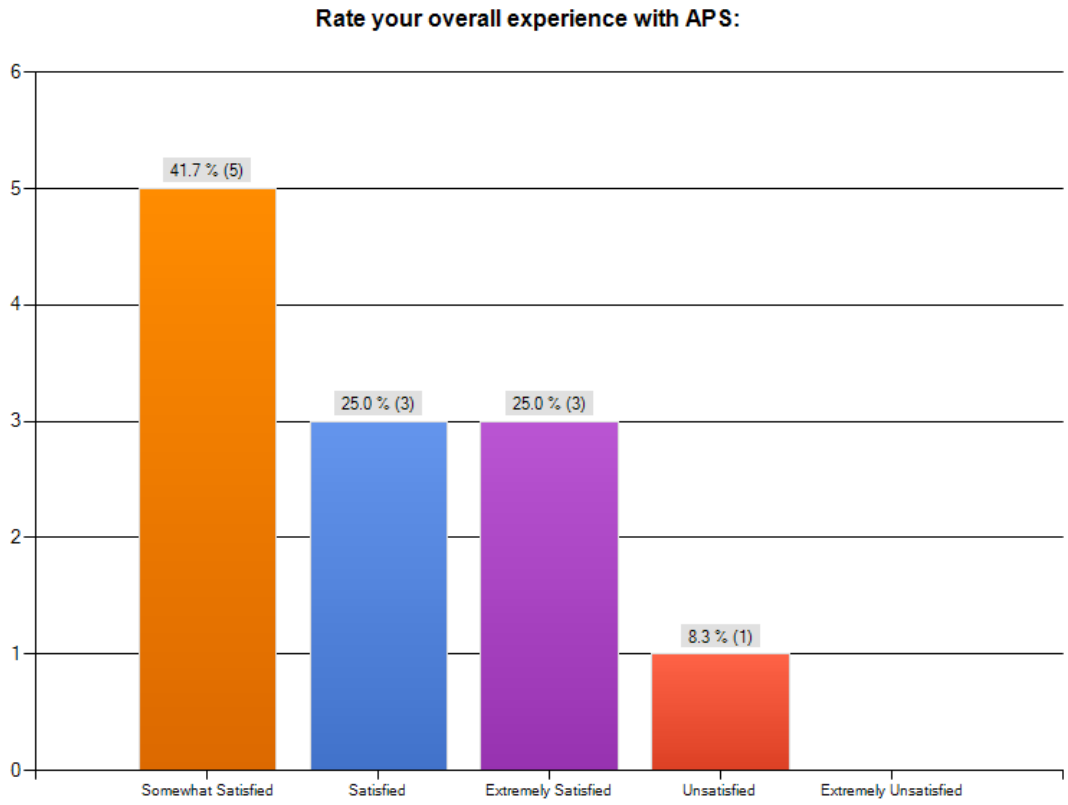
Number	Please be specific on any positive or negative reimbursements
1	There are a few codes that pay well but they do not make up for all those that don't . We lose a ton of money on Drs.
2	• The RVRBS rates for Psychiatric services are so low that unless you cost shift there is no way to pay for medical providers. The result has been for more and more extenders to be used. In every other Medicaid program, rates are reviewed and adjusted on an annual basis. The Clinic and Rehab rates were set without any basis. Some are too high. Most are too low. Cost shifting is done to make ends meet. Centers are criticized for providing the services that have a rate that is thought to be too high but the reality is that the rate was set high to encourage Centers to provide these more difficult services such as CSU and ACT. • Every other system has ways of reviewing rates on an annual basis and behavioral should as well.
3	In particular the professional service codes for medical providers and psychologists.
4	Adequate if the number of units meets the consumers' needs. In most cases that is possible under the current system. The adequacy is also contingent upon the BHHF funds need to meet the non-Medicaid service needs of the consumers.
5	Even in cases where reimbursement may be adequate, often the regulations and utilization guidelines prevent providers from offering the service.
6	None
7	• Positives: ACT, Crisis Stabilization Outpatient • Negatives: MD services

8	Very inadequate reimbursement rates for CFT, Supportive counseling, group therapies, psychiatric evaluation and medication management.
9	The current rates for Crisis Stabilization and ACT services are adequate. All other rates are too low to cover the expense to provide the services.
10	There has been very little change in Medicaid reimbursement rates for more than 10 years. Rates for some codes (services) have increased but some of the increase was offset by a decrease in the rates for other codes.
11	I've commented several times on previous questions.

Commentary and Analysis: The vast majority (81.8%) of the respondents felt that Medicaid reimbursements were very inadequate to totally inadequate. Many also noted that no increases had been made in many years other than a few codes, which recently received increases in response to Judge Bloom's intervention. However, even those codes with "adequate reimbursement" do not provide enough surplus revenue to offset overall financial losses. This is especially true since many of these codes were reportedly more challenging to obtain authorization for in sufficient numbers.

14. Rate your overall experience with APS:

Answer Options	**Response Percent**	**Response Count**
Extremely Unsatisfied	0.0%	0
Unsatisfied	8.3%	1
Somewhat Satisfied	41.7%	5
Satisfied	25.0%	3
Extremely Satisfied	25.0%	3
Please list any specific concerns and list any positive experiences		8
	answered question	**12**
	skipped question	**0**



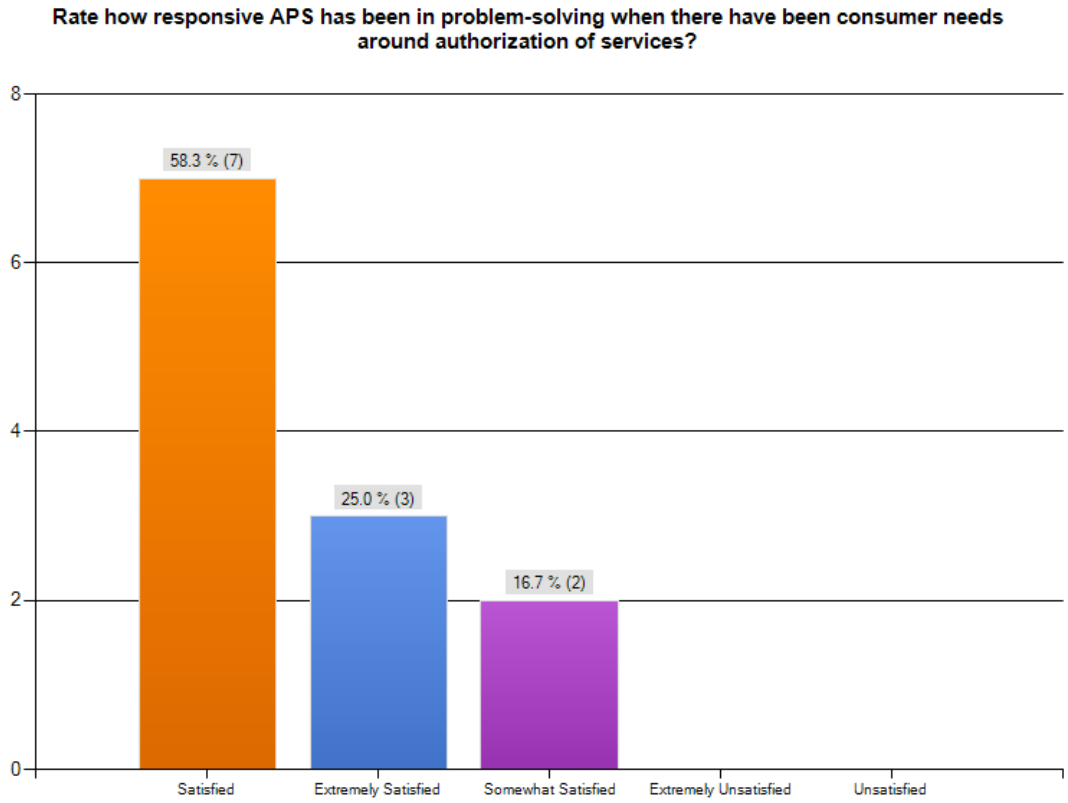
Number	Please list any specific concerns and list any positive experiences
1	They are responsive to requests. The problem is they march to the tune of BMS which is cut, cut, cut.
2	They were hired to do a job. They have been very professional. There are no surprises. They tell you this is what they are going to do, this is the time table, and then they do it. Excellent training and you can work with them to improve the overall quality of services. Consumers who need services will be approved for services.
3	Smooth authorization process - ELECTRONIC!
4	This Center's work with APS has been acceptable because we chose to work with APS in implementing changes wherever possible. Seeing how it can be done has worked better than fussing about what can't be done. The recent changes in Care Connection requirement cost the Center over $33,000 the Center could ill afford and was not a positive experience. It was tolerable if the reporting was to be single point and the process was to continue as is. With the MCO potential it would appear the expense was not worth the effort or the potential result. Three more reporting sources is not a positive change.
5	From an administrative point of view they are efficient. Communications with APS, both electronically and otherwise, is efficient. Auth requests / auth processing is very efficient. However, their interpretation of many BMS regulations / utilization guidelines are very restrictive. This has resulted in a decrease, and in some cases an outright elimination, of certain Medicaid services such as basic living skills, day treatment, targeted case management, etc.
6	• Very helpful • Willing to train; training is limited in effectiveness • review emphasize insignificant or incidental details to detriment of big picture of how the

	person was served • occasional subjective interpretation, causing system changes which get reversed next survey • exits are good experiences but written report is almost always much worse than what we are told
7	• Overall, APS has been very consistent in implementing BMS' policies. There has always been a willingness to provide technical assistance to providers. Unfortunately, APS' required "proprietary" assessment instrument is overly cumbersome and adds tremendous expense to the process. When providers were required to implement that process, there was no adjustment in rates to offset this added expense. • There has always been an unfair playing field when comparing the administrative/paperwork processing/documentation requirements placed upon the licensed behavioral health centers and private practitioners. Several years ago, after considerable political pressure, APS and BMS implemented a bizarre solution to address this issue. It involved dividing services into two groups: they were either "high end" services or "low end" services. Given that I do not have to disclose my identity, I confess that I still cannot comprehend this "solution" to the unfair playing field, other than private practitioners still do not have the administrative burden that is carried by the licensed behavioral health centers while the reimbursement rates are the same. BMS owned this solution, however it was clearly evident that it was the product of the APS think tank. • During the past year, there were significant changes to APS' Care Connection instrument. This was poorly conceived or certainly without adequate explanation or justification.
8	APS is always willing to provide assistance when necessary. Even though they are very stringent in their interpretation of the manual they are consistent.

Commentary and Analysis: The vast majority of respondents (91.7%) acknowledged a positive and professional relationship with APS. This response is consistent with feedback from the interview process and reflects the years of effort and resources that both parties have expended to make the current authorization process fairly routine. APS is generally understood to be a well-administered organization providing training and other assistance in a timely fashion. Concerns regarding the lack of authorization for some services still persist, although many felt that BMS and the state are ultimately to blame for that. The Comprehensives are very concerned about projected changes to the system linked to the introduction of the MCOs. Even with APS serving as the point of electronic contact, the expectation of additional information and required steps from each of three MCOs has many concerned, especially since many feel that they have already exceeded their administrative capacity to effectively comply.

15. Rate how responsive APS has been in problem-solving when there have been consumer needs around authorization of services?

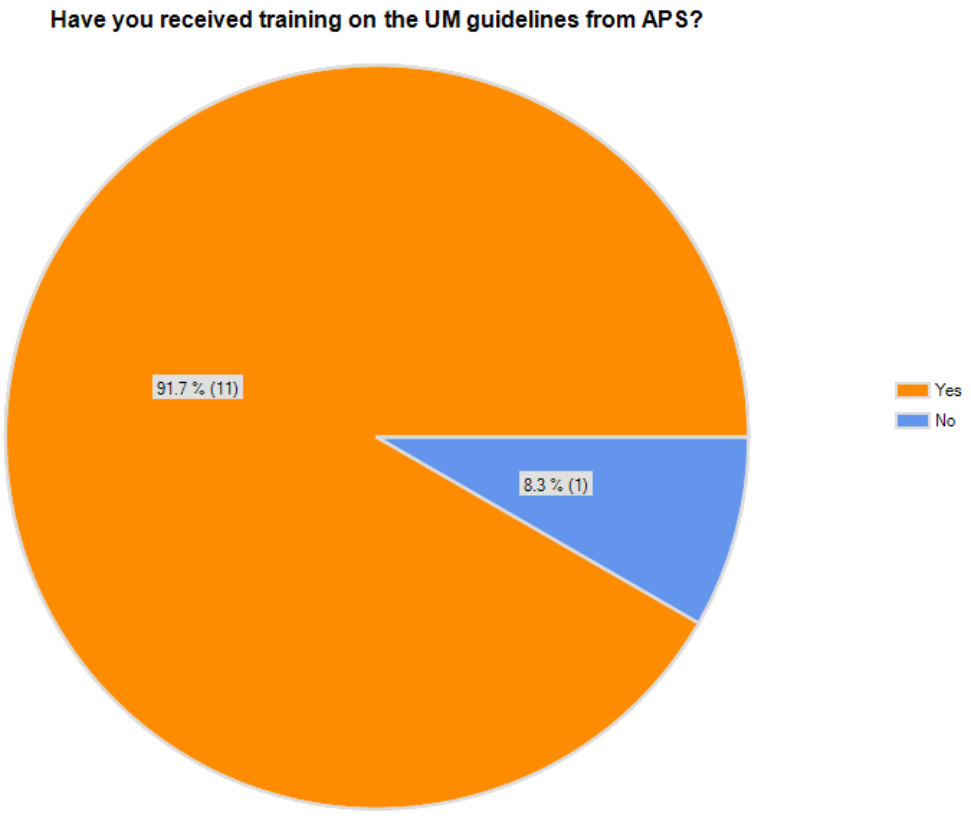
Answer Options	**Response Percent**	**Response Count**
Extremely Unsatisfied	0.0%	0
Unsatisfied	0.0%	0
Somewhat Satisfied	16.7%	2
Satisfied	58.3%	7
Extremely Satisfied	25.0%	3
Please list any specific concerns and list any positive experiences		4
	answered question	**12**
	skipped question	**0**



Number	Please list any specific concerns and list any positive experiences
1	No problems.
2	Usually we are responded to in a timely manner and if not we will continue to request (demand) a response until we have one. It is critical to have need answers to maintain the system and keep reporting accurate and complete.
3	None
4	Our care managers have been willing to assist in any way they can.

Commentary and Analysis: Consistent with the feedback obtained during the interviews, the majority of respondents (83.3%) were satisfied or extremely satisfied with the responsiveness of APS in problem-solving around consumer needs.

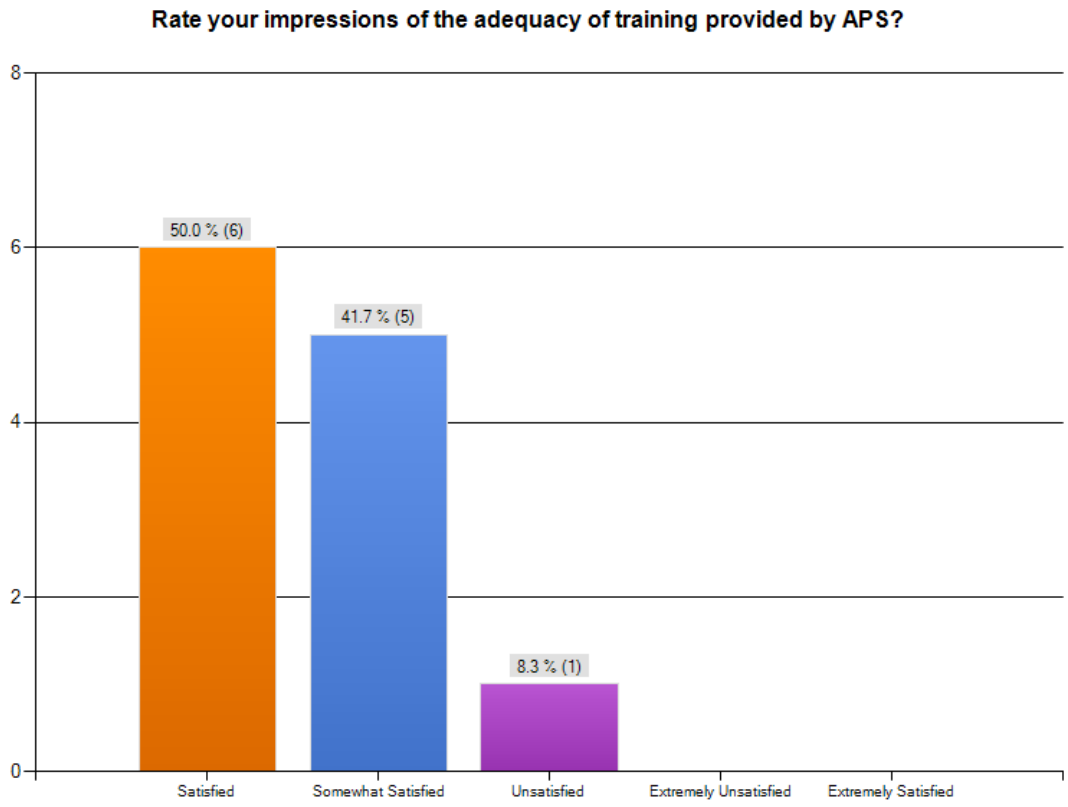
16. Have you received training on the UM guidelines from APS?		
Answer Options	**Response Percent**	**Response Count**
Yes	91.7%	11
No	8.3%	1
Comments		3
	answered question	**12**
	skipped question	**0**



Number	Comments
1	The guidelines are easy to understand and are written in a format that is easy to find answers to questions.
2	UM generally matches the XIX manuals and it is usually in interpretation where the Center and APS have disagreements.
3	None

Commentary and Analysis: Only one respondent felt that they had not received training on the UM guidelines largely confirming previous feedback that APS has been functioned professionally in its role.

17. Rate your impressions of the adequacy of training provided by APS?		
Answer Options	**Response Percent**	**Response Count**
Extremely Unsatisfied	0.0%	0
Unsatisfied	8.3%	1
Somewhat Satisfied	41.7%	5
Satisfied	50.0%	6
Extremely Satisfied	0.0%	0
Please list any specific concerns and list any positive experiences		5
	answered question	**12**
	skipped question	**0**



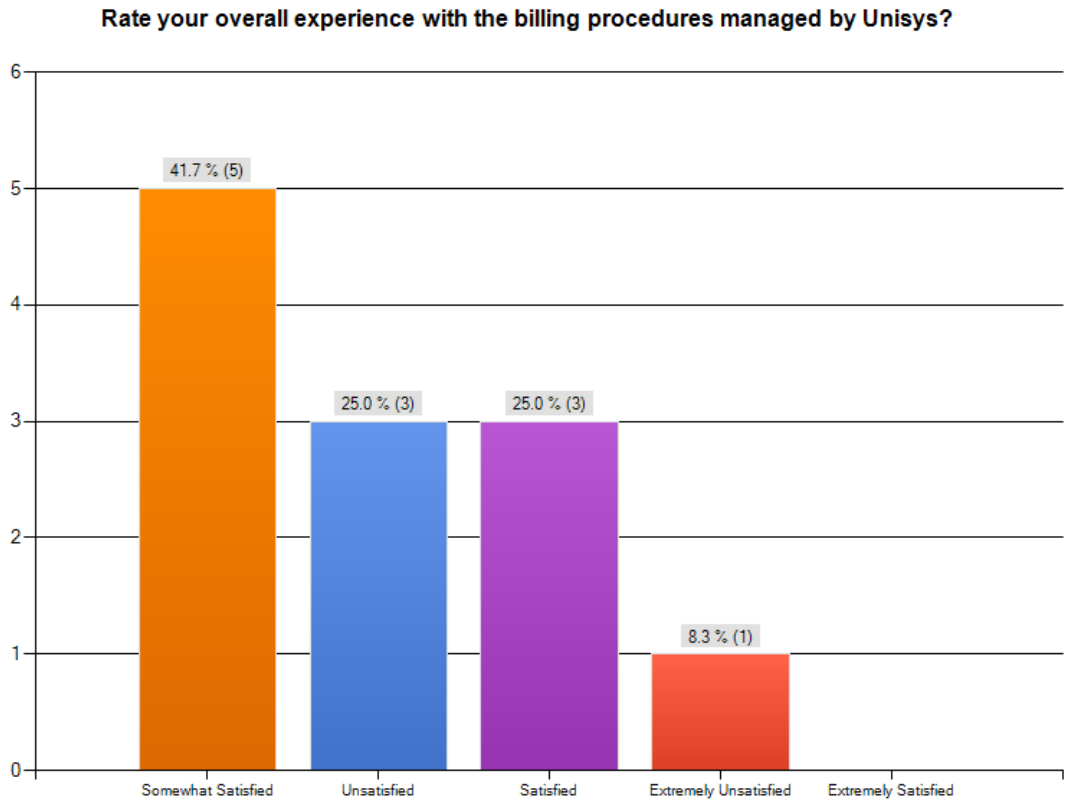
Number	Please list any specific concerns and list any positive experiences
1	Trainers have been inconsistent at best.
2	The trainers are prepared and willing to answer questions.

3	The interpretation of documentation requirements and medical necessity does seem to become more stringent/narrow. Documentation which meets standard one review will be inadequate next review.
4	The Center is satisfied as long as the reviewers follow the guidelines presented in training and are able to explain any exceptions and show where they occur in the UM manuals.
5	No comment --- see previous re: effectiveness

Commentary and Analysis: Impressions regarding the adequacy of the training is somewhat lower than in the preceding questions, but minimally 50% were satisfied and 41.7% were somewhat satisfied. Individual responses did indicate a lack of consistency among trainers and at times differences in interpretations from one trainer to another.

18. Rate your overall experience with the billing procedures managed by Unisys?

Answer Options	**Response Percent**	**Response Count**
Extremely Unsatisfied	8.3%	1
Unsatisfied	25.0%	3
Somewhat Satisfied	41.7%	5
Satisfied	25.0%	3
Extremely Satisfied	0.0%	0
Please list any specific concerns and list any positive experiences		7
	answered question	**12**
	skipped question	**0**

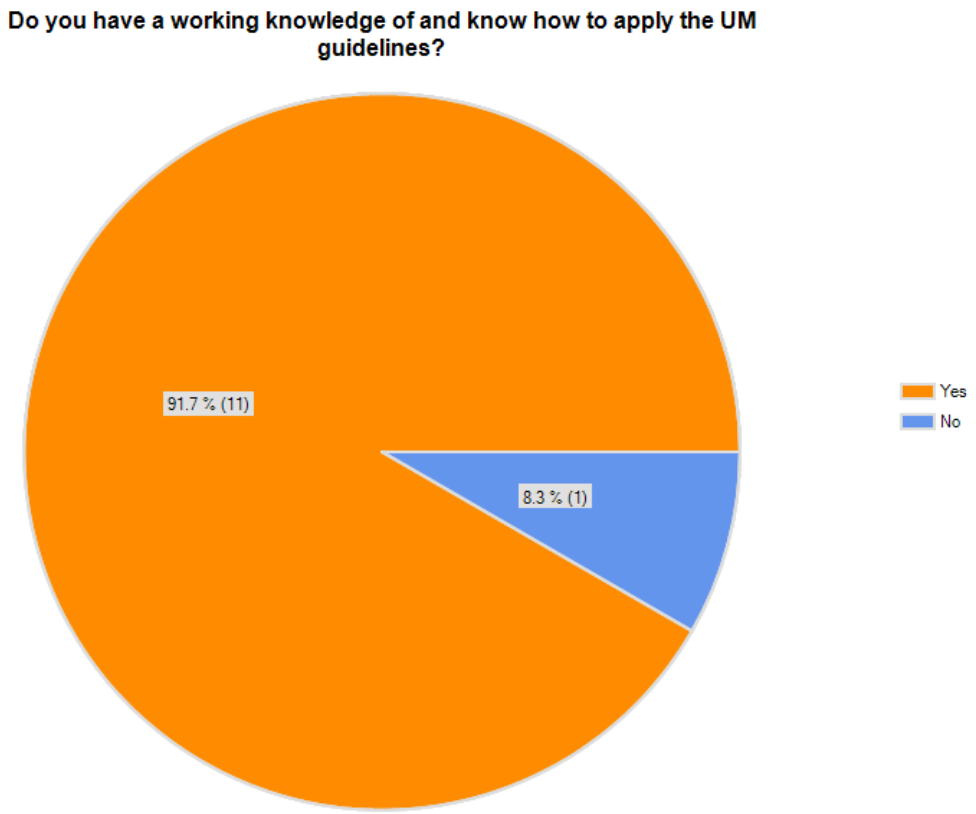


Number	Please list any specific concerns and list any positive experiences
1	Contact person has worked very well with us in order to assist in the billing process. No problems with process.
2	From a very rough start and a difficult transition the process has been developed over time and works well now. It works best when problems are identified and solutions recommended by both sides
3	There have been repeated problems over the past several years in dealing with Unisys. For example, we are currently dealing with a breakdown in communications between APS and Unisys which often results in claim denials because Unisys has not received service authorization information from APS.
4	There are times when 'switches" or "edits" occur which make changes and the system denies, closes or otherwise creates problems. Agencies must then 're-bill', which costs time and money
5	Slow, confusing for a long time.
6	• When a provider has a denied claim or any other question regarding a claim, the provider is limited to only 5 claims per phone call. You can hang up and then call again and address an additional 5 claims. • Typically, if APS has submitted the authorizations to Unisys per established protocol, there is no problem with Unisys processing payment. The problems occur when Unisys informs the provider that they have not received the authorization from APS. When the provider then contacts APS, they are told that the authorization was sent to Unisys. It quickly becomes a situation with Unisys blaming APS and APS blaming Unisys. It is not a

	question of whether the provider has submitted the appropriate information, it becomes an issue between Unisys and APS with the provider caught in the middle and not getting paid. • The above issues require additional resources from the providers that, once again, has not been factored into the rates that have not increased over the years.
7	It's not very easy to get an explanation as to why a claim may pend or deny. There are still problems with crossovers.

Commentary and Analysis: Impressions of Unisys's role in the billing process are more bi-modal with 66.7% somewhat satisfied to satisfied, while 33.3% were unsatisfied to extremely unsatisfied. Individual complaints largely centered on communication breakdowns between APS and Unisys resulting in denied or delayed payments for providers.

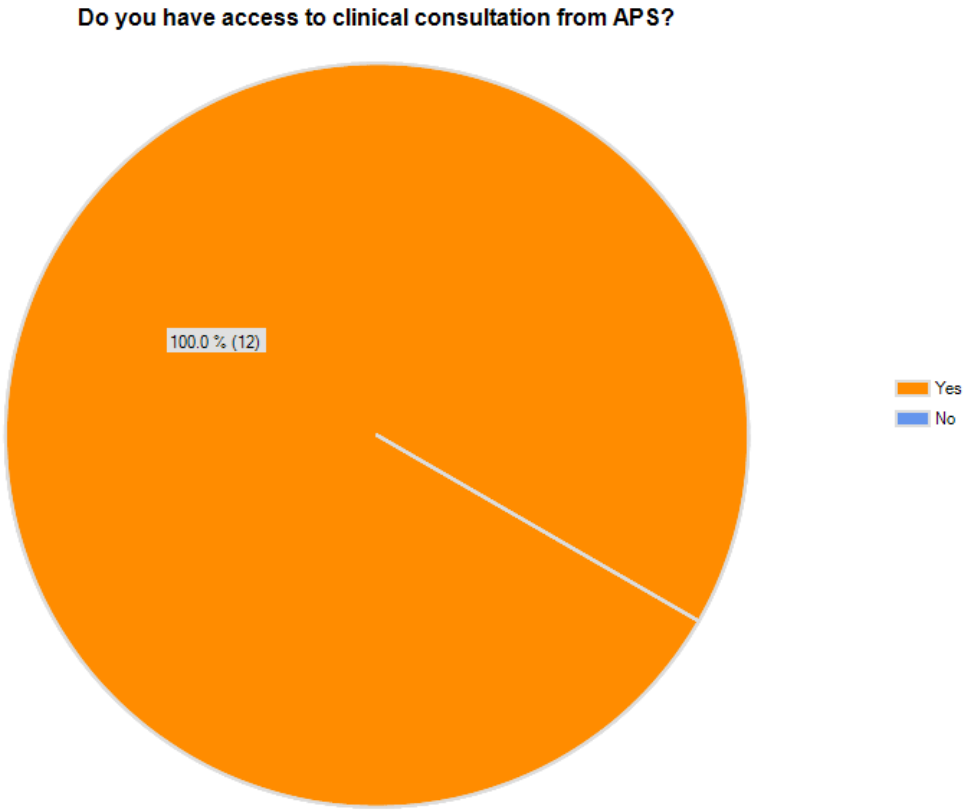
19. Do you have a working knowledge of and know how to apply the UM guidelines?		
Answer Options	**Response Percent**	**Response Count**
Yes	91.7%	11
No	8.3%	1
Comments		2
	answered question	**12**
	skipped question	**0**



Number	Comments
1	We read the regulations and the UM Guidelines. The guidelines offer guidance with regard to all the required elements needed to meet the regulations. Where we have found variance we have point it out to APS.
2	None

Commentary and Analysis: All but one of the respondents felt they had a working knowledge of the UM guidelines, although during interviews many indicated that it took time for them to "get on the same page as APS." Most also felt APS's interpretation of the guidelines was often too restrictive and not consistent with other states.

20. Do you have access to clinical consultation from APS?		
Answer Options	**Response Percent**	**Response Count**
Yes	100.0%	12
No	0.0%	0
If yes, for what service types? Other comments		7
	answered question	**12**
	skipped question	**0**



Number	If yes, for what service types? Other comments
1	They are available in a fashion for help, but it is mostly on documentation
2	All services that we bill.
3	• Most recently - Individual therapy • Previously - Individual therapy, TCM, Treatment planning
4	More to the fact we provide Clinical consultation and have a peer relationship with the APS clinicians.
5	None
6	• Consultation has been available for therapeutic and case management. • Oftentimes the consultation is not comprehensive enough and it is also inconsistent. (one time something will be okay and the next time is not)
7	All

Commentary and Analysis: All respondents acknowledged that they had access to clinical consultation from APS, although there were some minor concerns that it might not be all that helpful or useful.

21. How many denials have you had in the past year?

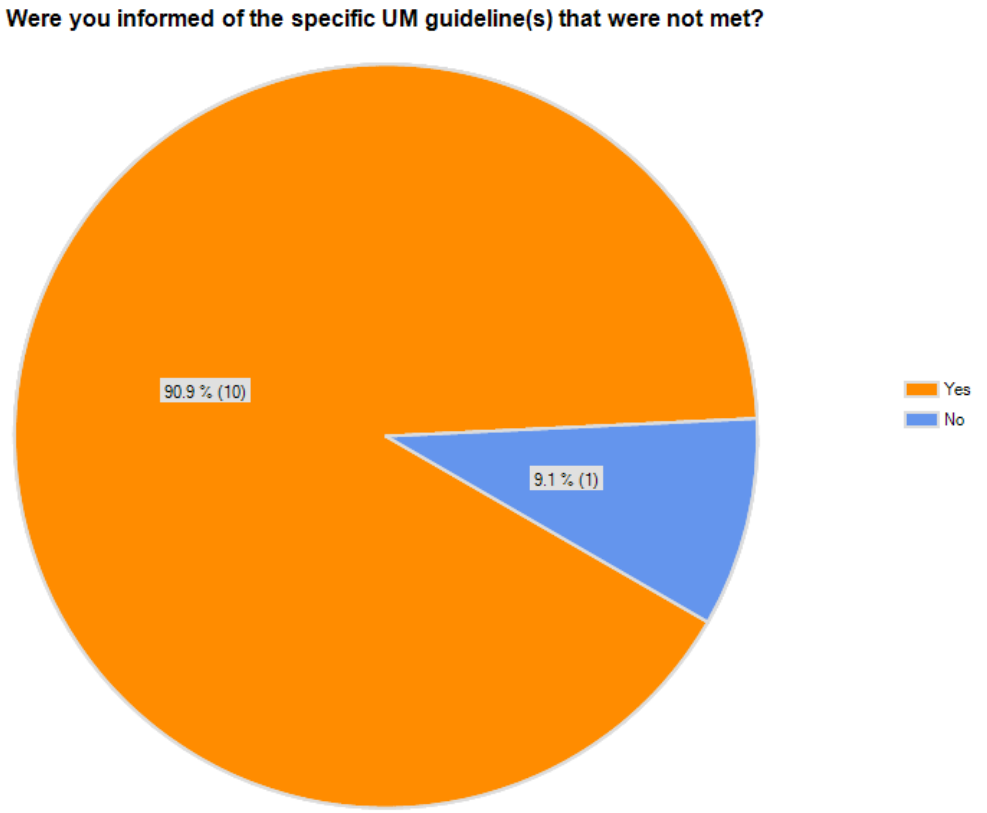
Answer Options	Response Percent	Response Count
Please indicate number:	90.0%	9
Comments:	70.0%	7
	answered question	**10**
	skipped question	**2**

Number	Please indicate number:
1	(Empty field)
2	None
3	0
4	None that were not justified or corrected by us or by them
5	0
6	NONE see below
7	Hundreds
8	35
9	???
10	None

Commentary and Analysis Most respondents to the survey indicated that they have experienced few or no formal denials of authorization request, which is consistent with feedback received from APS. However, as noted earlier in this report, this feedback might be somewhat misleading. The Comprehensives reported routinely being asked to "revise" initial authorization request by APS. Typically that translates to a reduction in service but apparently is not

considered a "denial." In addition, disallowances during retrospective reviews are also not coded as a "denial." Combined with the fact that most Comprehensives have in their words "learned" not to request certain services it is not surprising that so few denials are being recorded.

22. Were you informed of the specific UM guideline(s) that were not met?		
Answer Options	**Response Percent**	**Response Count**
Yes	90.9%	10
No	9.1%	1
Other (please specify)		6
	answered question	**11**
	skipped question	**1**



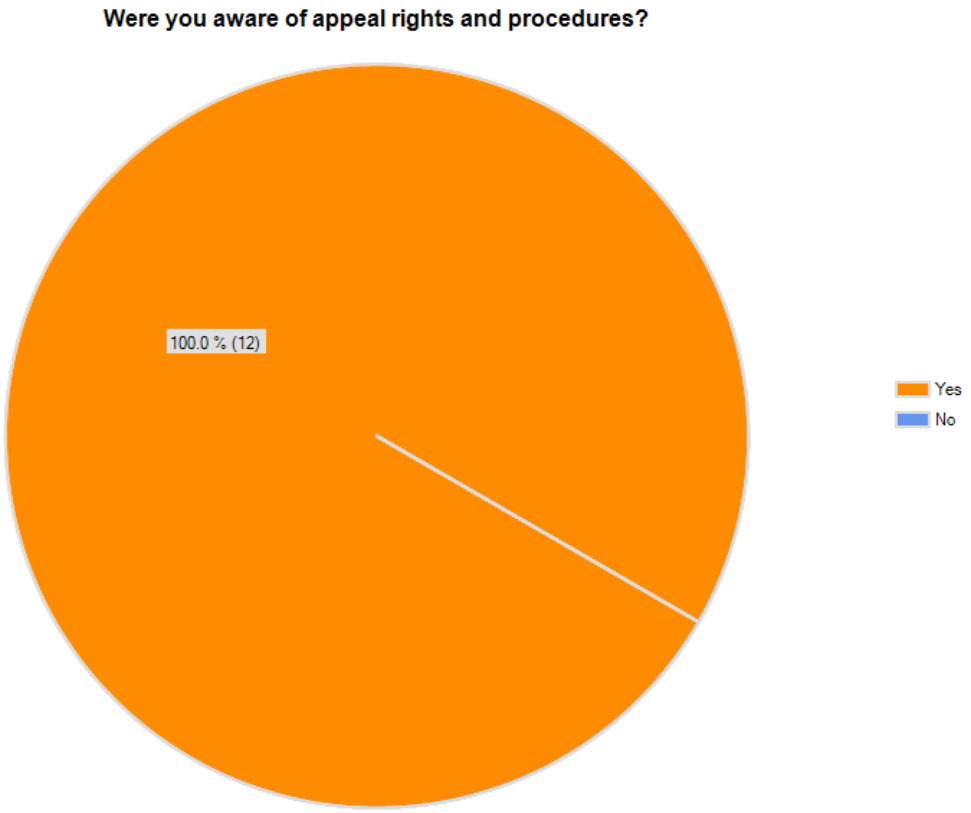
Number	Other (please specify)
1	N/A, no denials.
2	No denials.
3	Or we showed where the guidelines were met and they missed the justification or the need for exception.

4	APS has made it clear they do not want to deny services. Therefore we often retract our request instead of require a denial. Additionally, to push for a denial, you must submit significant amounts of records, which results in a lot of work, especially when you know it will result in a denial of service. They also tell you ahead of time they will deny certain requests if you send them, so often the requests are not even sent.
5	None
6	The reason code is always listed on the paperwork we receive from APS.

Commentary and Analysis: The results showed that all but one respondent felt that they had been informed of the specific UM guidelines that were not met. However, the narrative responses again suggest that the low number of denials is likely artificial.

23. Were you aware of appeal rights and procedures?

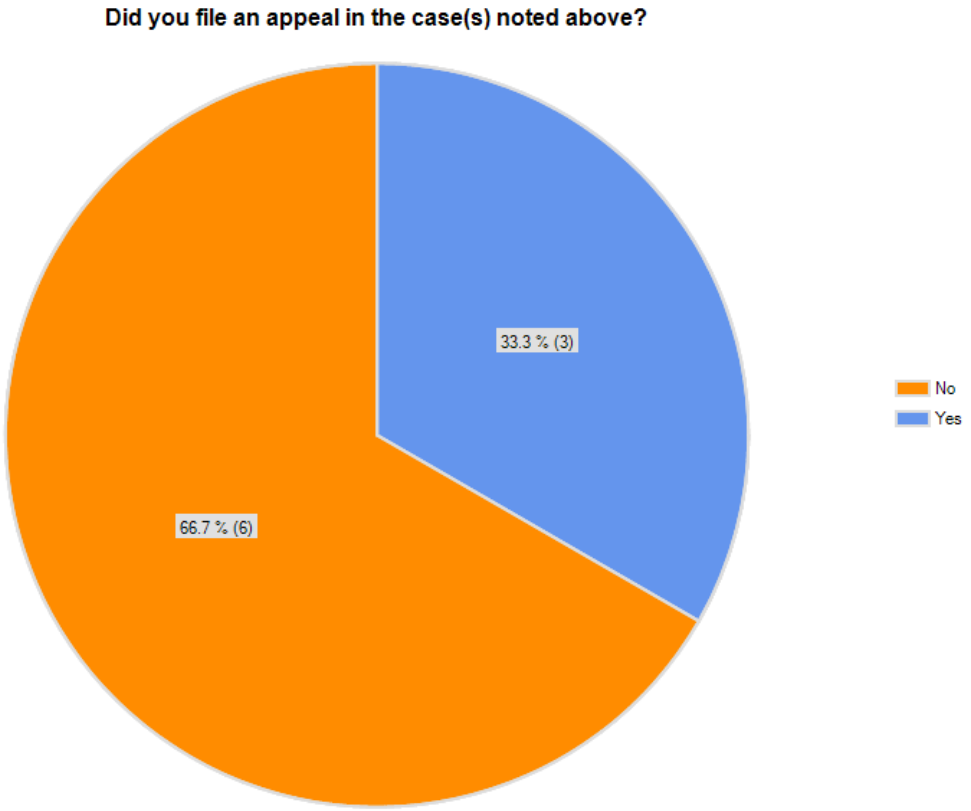
Answer Options	**Response Percent**	**Response Count**
Yes	100.0%	12
No	0.0%	0
Comments:		5
	answered question	**12**
	skipped question	**0**



Number	Comments:
1	N/A, no denials.
2	No denials.
3	It in the manuals.
4	None
5	You needed to add a "Somewhat" button! You can appeal. They will review. In the absence of any written criteria, you still lose. If you have a BA level staff do an OHFLAC required intake assessment (takes up to one and one half hours & includes history, assessment of functioning capacity in all areas necessary to function independently in the community, listing of strengths/assets and weaknesses/support needs) on a new client and if the client then sees the Psychiatrist on the same day (because they are exhibiting serious symptoms of mental illness) to be evaluated for medication, APS has, during the last year, determined that you have performed the same service twice on the same day. That is a very bad thing according to APS. Even though the intake (as a separate procedure) is required by licensure and is totally unlike a psychiatric evaluation, it is unacceptable, not allowed and duplicative. There is nothing in BMS Manuals or APS guidelines that would suggest that this is such a bad thing, but a provider most definitely will receive a "zero" during an APS review for each occurrence.

Commentary and Analysis: All respondents acknowledged being aware of appeal rights and procedures. However, commentary and feedback from previous interviews suggests that a general apathy exists and appeals are seldom filed.

24. Did you file an appeal in the case(s) noted above?		
Answer Options	**Response Percent**	**Response Count**
Yes	33.3%	3
No	66.7%	6
If yes, what was the outcome? (Denial upheld, overturned, modified?) Other comments.		6
	answered question	**9**
	skipped question	**3**



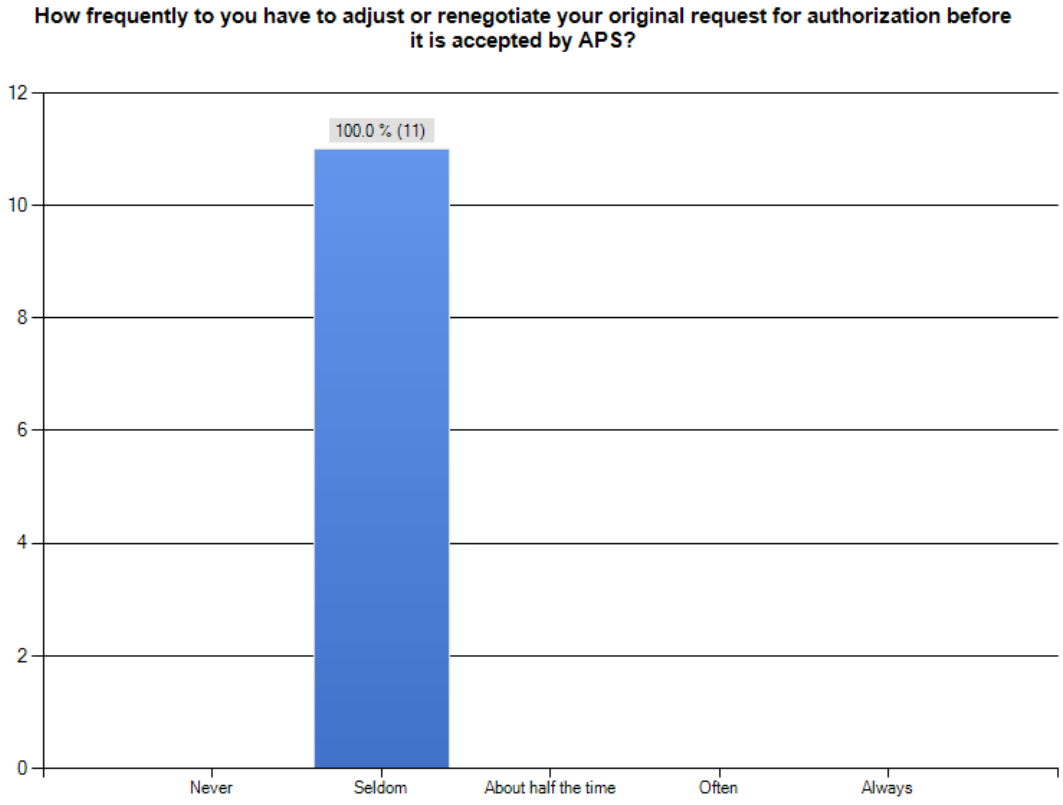
Number	If yes, what was the outcome? (Denial upheld, overturned, modified?) Other comments.
1	N/A, no denials.
2	No denials.
3	Seldom have had a need to appeal since it is easier to do it right the first time. This would be a different answer if it were XIX MR/DD waiver.
4	None

5	If the case was denied and we felt it was denied in error, we would appeal or we would call and they (APS) would explain how to modify to get the auth adjusted.
6	Without citing any written policies or guidelines, our appeal was denied.

Commentary and Analysis: As noted in the earlier question, few if any appeals are filed.

25. How frequently to you have to adjust or renegotiate your original request for authorization before it is accepted by APS?

Answer Options	Response Percent	Response Count
Never	0.0%	0
Seldom	100.0%	11
About half the time	0.0%	0
Often	0.0%	0
Always	0.0%	0
Comments:		5
	answered question	**11**
	skipped question	**1**



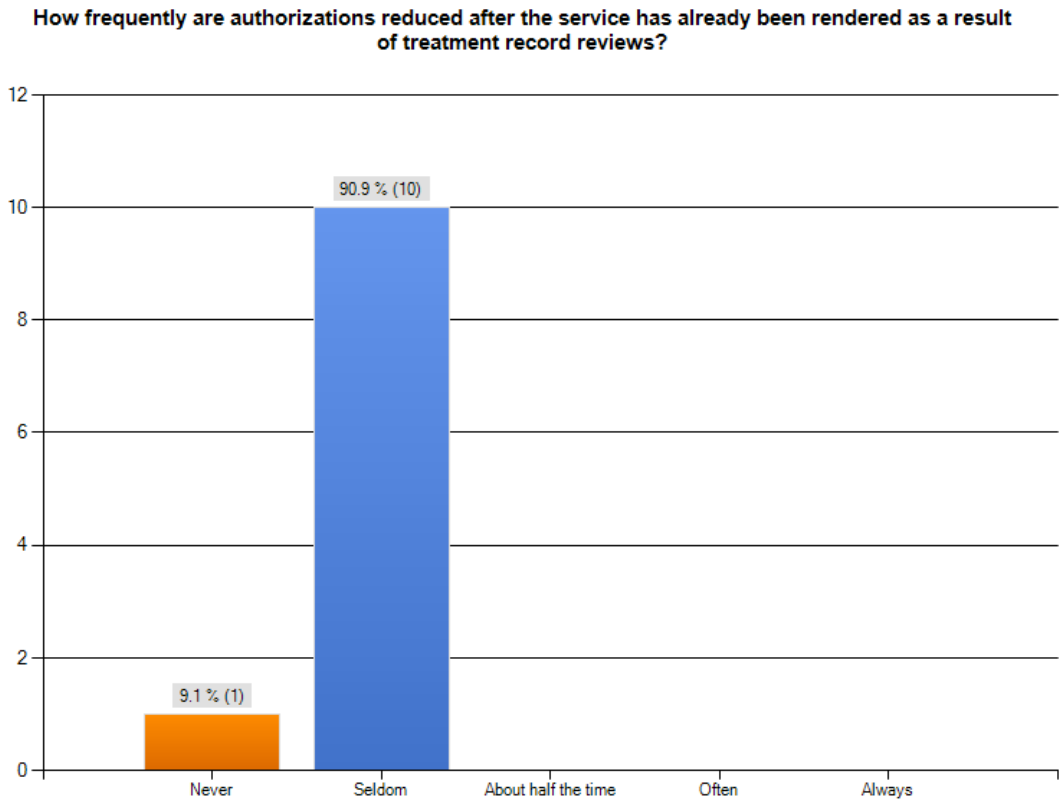
Number	Comments:
1	Additional information is typically provided and then authorization is granted or agency closes

	the request.
2	We ask for what we know we need and what we know is appropriate.
3	This is very difficult to answer. It depends on the service. Some services result in renegotiations on a very regular basis. Others are seldom, if ever renegotiated.
4	None
5	More than seldom but less than half the time

Commentary and Analysis: All respondents noted that they rarely renegotiate original authorization request. Again, this is likely somewhat misleading since most providers report that they have "learned" to modify their initial request to comply with historical decisions by APS. In addition, some suggested that "informal" channels still exist by which original authorization requests are often revised prior to final approval.

26. How frequently are authorizations reduced after the service has already been rendered as a result of treatment record reviews?

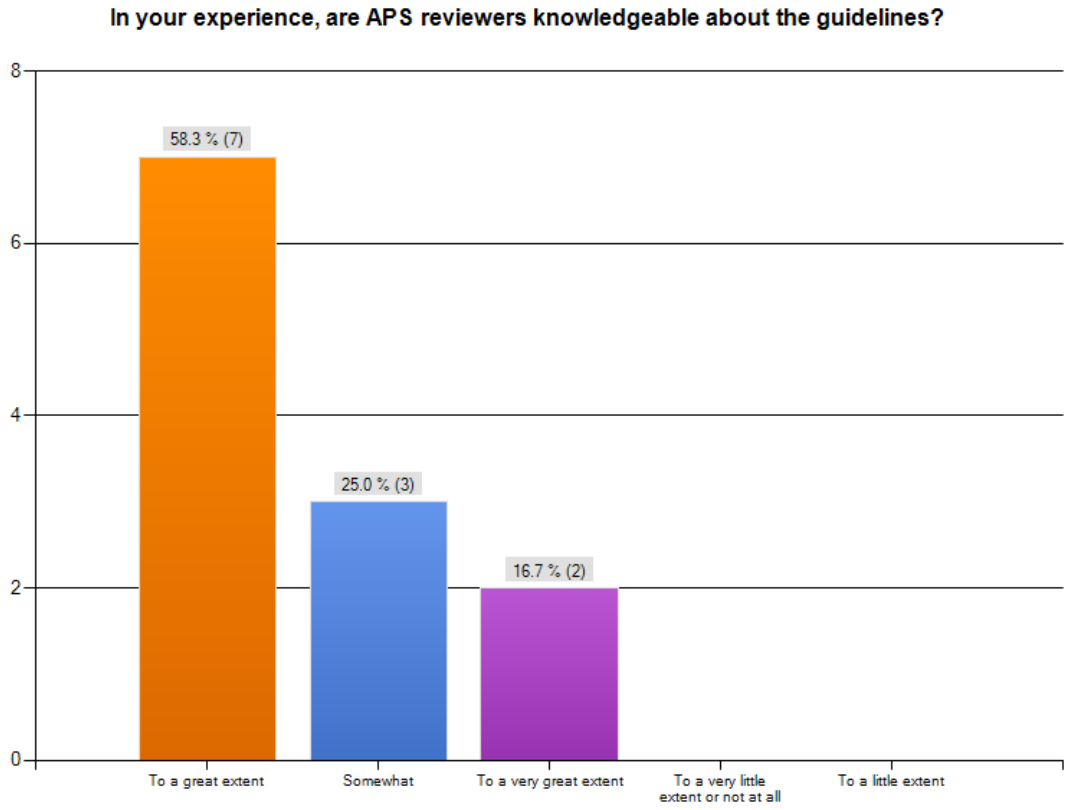
Answer Options	**Response Percent**	**Response Count**
Never	9.1%	1
Seldom	90.9%	10
About half the time	0.0%	0
Often	0.0%	0
Always	0.0%	0
Comments:		3
	answered question	**11**
	skipped question	**1**



Number	Comments:
1	Text box allows for the request exceptions and clinically justified exceptions are seldom denied. Our clinicians know clinical needs and are prepared to justify request.
2	Again, this is very difficult to answer, as it depends so much on the service. Certain services, like day treatment or basic living skills, are always reduced. In some cases a 100% rollback. Other services rarely, if ever have authorization reductions during retrospective reviews.
3	None

Commentary and Analysis: Consistent with feedback from the interviews, the majority of respondents reported that they seldom if ever have authorizations reduced as a result of retrospective record reviews. As noted previously, this is more a reflection of the current status, since most Comprehensives reported that this was a regular occurrence in the past. Again, Comprehensives indicated that through a process of trial and error they now know what will and what will not be approved and they simply attempt to design treatment interventions to match this reality.

27. In your experience, are APS reviewers knowledgeable about the guidelines?		
Answer Options	**Response Percent**	**Response Count**
To a very little extent or not at all	0.0%	0
To a little extent	0.0%	0
Somewhat	25.0%	3
To a great extent	58.3%	7
To a very great extent	16.7%	2
Comments:		5
	answered question	**12**
	skipped question	**0**

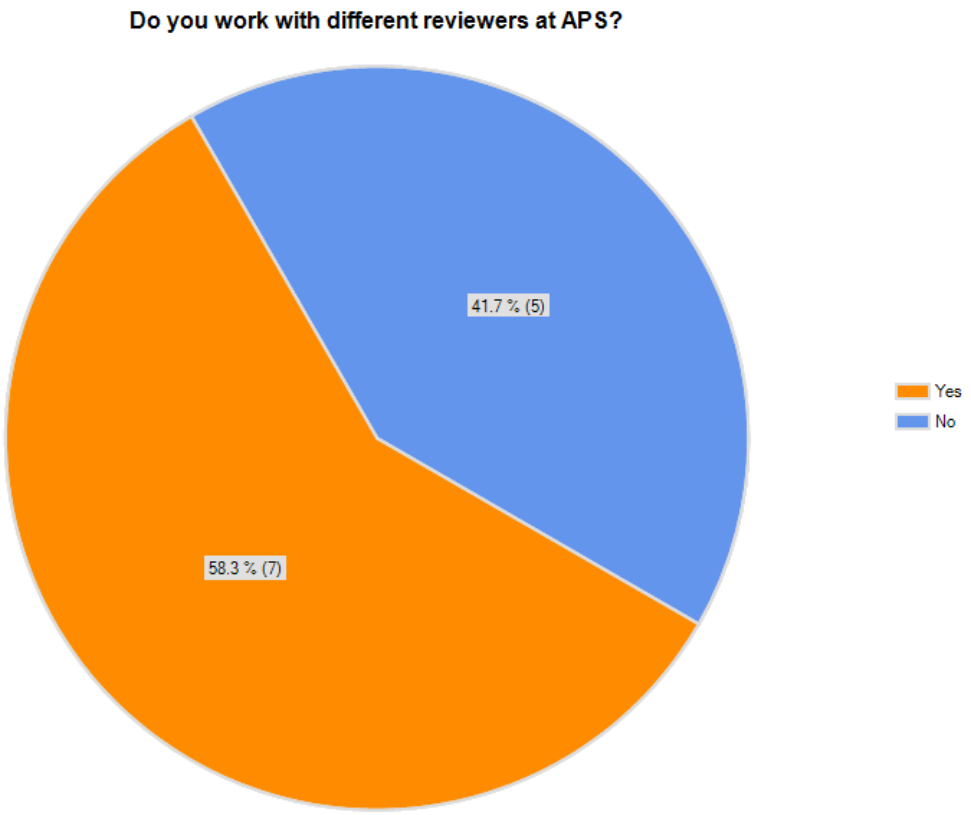


Number	Comments:
1	However, as mentioned above the interpretation seems to narrow.
2	APS reviewers know the letter of the manuals and sometimes have to be reminded of the clinical implications of the request being made or the reason why documentation is more appropriate than some of the recommended examples.
3	note previous re: subjective interpretations
4	• APS has been more professional than most Providers and they are usually reasonable. But

	make no mistake about it, APS is a Managed Care entity for all intents and purposes. Since 2000, the Involuntary Commitment rate in WV has increased by 330% correlation with the initiation of this managed care entity, thought they should not be blamed entirely for the Commitment problem. • My point is the current DHHR movement to push Behavioral Healthcare toward the three MCOs in the State adds a second level of managed care on top of APS. Given the results indicated above and with respect to the Medicaid redesign debacle, developing a Behavioral Health System would be smarter.
5	As indicated earlier, many of the APS staff previously were employed by one of the providers. It is amazing to see the breadth of their expertise expand with a significant pay raise. Quite often during site visits, APS reviewers provide subjective findings. When asked for supportive documentation for these findings, they are not provided.

Commentary and Analysis: The results suggest that the Comprehensives largely believe that APS reviewers are knowledgeable and educated on the UM Guidelines. However, the narrow interpretation of the guidelines continues to be a point of contention.

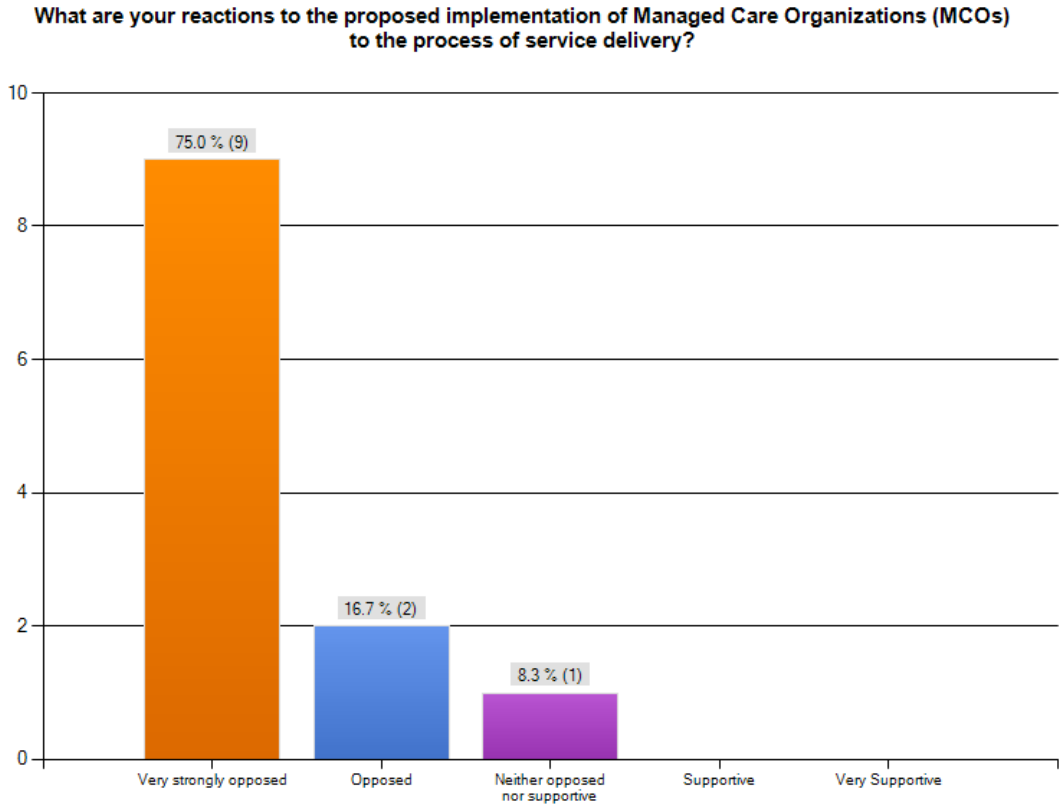
28. Do you work with different reviewers at APS?		
Answer Options	**Response Percent**	**Response Count**
Yes	58.3%	7
No	41.7%	5
If yes, in your experience do they apply the guidelines consistently?		6
	answered question	**12**
	skipped question	**0**



Number	If yes, in your experience do they apply the guidelines consistently?
1	No
2	• Equal expectations for all reviewers. • This Center seems to be reviewed more stringently than some of the other Center's. We have seen the documentation and processing and do not understand the variance in percentages arrived at in final reports. Reviewer variance is the only explanation we can guess at.
3	For the most part
4	FAIR inter-rater reliability noted
5	Although we have the same two reviewers, the guidelines are not consistently applied.
6	No

Commentary and Analysis: Slightly more than half of the respondents indicated that they have had different reviewers over time. Although this is likely neither significant nor avoidable, the potential lack of consistent interpretation of the guidelines at times is clearly problematic.

29. What are your reactions to the proposed implementation of Managed Care Organizations (MCOs) to the process of service delivery?		
Answer Options	**Response Percent**	**Response Count**
Very strongly opposed	75.0%	9
Opposed	16.7%	2
Neither opposed nor supportive	8.3%	1
Supportive	0.0%	0
Very Supportive	0.0%	0
Comments:		10
	answered question	**12**
	skipped question	**0**



Number	Comments:
1	One of the WORST things WV could do to our consumers.
2	I believe that the system is already managed and that the changes would only increase administrative overhead and create more problems. We currently have a system that allows for electronic authorizations, EOB, and payments. While they are now promising to do these in the future, the new system was completely paper or phone based which means more administrative cost. The additional dollars used to pay the MCOs will come from direct services in a system that is already in need of better rates and more services.
3	• See above comments about MCOs and consider the old saying "If it ain't broke don't fix it" • Multiple administrations and multiple processes never made anything easier.
4	With the implementation of APS in or about 2000, we have seen a massive reduction in the

	amount of services available for those with mental illness and substance abuse. As I understand it, APS's financial performance is not directly tied to the amount of service they authorize - and we still saw a massive reduction. The financial performance (profit) of the MCOs WILL be directly tied to how much service they authorize. This would logically lead to a an even greater reduction in service availability.
5	• lack of consistency in services • lack of consistent auth process • inconsistent UM guidelines • payment process issues • contracts are different and use different language
6	See #27 above
7	More implementation time is needed for this process to be successful.
8	In spite of some of the previous negative statements re: APS, APS has provided stability and professionalism to a very weak BMS. APS has implemented an authorization system that assures that medical necessity is established per BMS' guidelines on a consistent basis. It is not perfect, but in all of the individual and group meetings with the MCO reps and (no longer there or in hiding) DHHR staff, it is clear that implementing the MCO concept as presented would cause considerable harm to Medicaid recipients. The most curious and bizarre explanation, was that the MCOs involvement was West Virginia's plan to bring about integration of Primary Care and Mental Health. No doubt innovative, unquestionably embarrassing and a clear demonstration of ignorance!
9	• This is a confusing, inefficient, unnecessary idea. We have been in a managed care environment since the state contracted with APS. This proposed change just adds layers of additional paperwork, confusion for both providers and consumers, additional cost to an already stressed system. It makes no sense as proposed. • It is not about integration it's about cost cutting. However, it is doubtful that there will be a reduction in overall costs due payment to the MCOs.
10	There is nothing to be gained by going with an MCO. More money will be extracted from the system to provide profit margins for the MCOs. We've been managed just fine by APS for 10 years and if there's any extra money it needs to be put into increased rates.

Commentary and Analysis: The vast majority (91.7%) of the respondents were strongly to very strongly opposed to the idea of implementing an MCO model. Narrative comments expressed similar fears voiced during the interviews that the administrative and related demands of a totally managed system will have devastating consequences for providers and consumers alike.

30. What are your specific thoughts on the proposed implementation of Managed Care Organizations (MCOs) to the process of service delivery?

Answer Options	Response Count
	11
answered question	**11**
skipped question	**1**

Number	Response Text
1	Besides being a admin nightmare, it will reduce access, reduce volume and reduce rates.
2	Based on my knowledge of their system, low end services will not be a problem since authorizations will not be needed. The high end services would then have to be reduced to provide the payment to the MCOs. This would mean less authorizations for CSU, ACT, CCSS,

	etc.
3	• Further restricts availability of services to consumers • Places further financial overhead on already strapped providers • Is steps backwards as MCOs do not even have electronic authorization processes available
4	See reports provided to BMS by the WVBHPA
5	The clear financial incentive for the MCOs is to reduce the amount of community based service authorized. In addition, there appears to be an incentive for the MCOs to shift even more clients to the state hospital. If the client is sent to the state hospital, the MCO continues to receive its PMPM payment for some period of time after the client has left the community and gone to the hospital. Therefore, the state is paying both the MCO and the state hospital simultaneously for the same individual's care.
6	• From UM: MCOs might provide a more streamlined system • From finance: MCOs need EDI auth process, approval/denial/unit/service etc. mentioned using faxes and letters et which will drive up cost • Medical home emphasis is problematic for very large providers with 1000's of consumers
7	• They are Managed Care. They ratchet down utilization to make money. If you currently assume that a lack of adequate community services heavily contributes to our Behavioral Health crisis, then for our DHHR leaders to again strike on the very process to further reduce care seems less than informed and treatment oriented and, regrettably, short-sightedly driven to lower cost. • I would argue however that APS; a historical lack of community service funding and lethargy on behalf of some Providers has caused the Commitment Rate to rise and overall cost to go up because inpatient care (State Hospitals and Diversion Hospitals) is the most costly. The $10M - $12M/year that BHHF spends on diversion costs could have been put to much better use from 2000 - 2010 by investing in Community Services. • Confronted with the same problem now, DHHR's solution seems to be once again--- Managed Care albeit with a twist, i.e. a "second level", now on top of APS, and please don't tell me that APS isn't Managed Care but an Administrative Organization. • Wasn't it Einstein who said "to apply the same solution time and time again in the face of continued failure is the definition of insanity"?
8	• Four different procedures for billing and prior authorization requests (including Molina) (electronic and paper claim) • Client being able to change carriers monthly • Each has their own deadline for claims submission and rebills • Different rules for retro billing and backdated medical cards • Carelink does not have electronic billing capability • Carelink will not be able to handle the prior auth process smoothly. They have a very slow response to auth requests. We are now dealing with a four-month lag. • Documentation requirements of MCOs are less stringent than APS (positive)
9	• I think that it enough. Okay, given that DHHR signed an AGREED ORDER per the Hartley court case that they would invest 50+ million dollars in the first three year (beginning 7/1/09) to expand community based services and within that court order there were many items that clearly would be paid for by Medicaid, how does it make any sense to then set up a competitive capitated system of care for behavioral health services? • This question was asked many times. Knowing that it would be asked again, one would think they would prepare an answer, even if it made no sense. They couldn't even do that. They continued to mumble or chose not to show up at legislative hearings.
10	The intent of managed care is to reduce expenditures. Reduction of expenditures = less service. Funds spent on the MCO system could be spent to improve client care.
11	Someone in state government seems to think that Behavioral Health has "fat" to lose which can't be further from the truth. We have seen a reduction in expenditures steadily since 1995. Going to a capitation based system with the MCOs will just set us backwards because they can't handle the huge volume of authorizations electronically as we have now with APS. Our current system is cost effective and streamlined. We just need a few adjustments in reimbursement and some additional codes to cover all of our services.

Commentary and Analysis: The majority of comments indicate a strong belief that the MCO implementation will result in reduced resources and ultimately less service options for consumers in an already "starved" system of care.

31. Please provide any additional information or commentary regarding the service delivery system in West Virginia that you feel is warranted:	
Answer Options	**Response Count**
	7
answered question	**7**
skipped question	**5**

Number	Response Text
1	• The behavioral health system in WV has faced reductions in service array, number of available visits and in some instances even in reimbursement for services. Any further restrictions or reductions will result in inability to meet consumer needs in community placement and require more intrusive, more expensive inpatient treatment. • There will always be situations in which inpatient services are needed; however, many individuals are willing to go inpatient on a voluntary basis and are denied access due to absence of a funding source. Private hospitals will not accept without insurance. Involuntary commitment then occurs which results in rights.
2	The system is older and more efficient than may and has worked and can work extremely well if it is not dismantled and moved to a multiple payor source "MCO'S) from a single payor source.
3	• too adversarial between agencies and state • joint decisions and mutually-agreed management needed • system has waste and inefficiency because of excessive compliance requirements and poor communication • state agencies do not communicate among themselves... multiple standards
4	Thanks for the opportunity but I think I got most of it out.
5	• State Hospital is currently not able to track and report to the comprehensives the clients that are there from their region. Our center is not being notified of discharges to our community. When we call the hospital to check to ask if there are clients from our area, they are not able to tell us. • Recently we had a suicide when someone was discharged to our region and we were not notified of the discharge.
6	Enough, I'm tired. But I did get something to you by the deadline. I know, you did have to beg and you did have to extend the deadline, but I hope some of this helps. Now, go and write a good report, we're counting on you!
7	For those of us who have worked in this system for 30+ years, we've seen it all and we know what it takes to make it work. All you have to do is ask, and we appreciate this opportunity to share our knowledge. Please share the results with us. Thanks!

Commentary and Analysis: Narrative responses are again very consistent with the feedback obtained during the interview process. Respondents have grave concerns with the current system of care in West Virginia. They are equally apprehensive regarding the perceived negative impact that the implementation of a managed care system will have, especially without the support of a legitimate and workable "plan" for behavioral health that has the consensus of all stakeholders.

VIII. SALIENT REPORTS ON THE SYSTEM OF CARE IN WEST VIRGINIA

As noted previously, the status of behavioral healthcare in West Virginia has been the subject of numerous evaluations and assessments during the past few years. Experts representing various constituents including state government, providers, consumer and advocacy groups, as well as state sanctioned commissions and national consulting organizations have produced multiple reports and findings on the current health of the system. It was not within the original design of this project to thoroughly explore these reports, however it is hard to overlook the common theme running through them. Regardless of the approach, specific audience or individual focus, all of these various reports are in agreement that the behavioral healthcare system in West Virginia is in severe crisis. Shared findings include the absence of a full continuum of care, funding and geographic barriers to treatment, poor state leadership and vision, excessive and restrictive layers of bureaucracy, and the lack of a comprehensive state-wide plan which incorporates the principles of wellness and recovery and evidence based practice. Perhaps the following quote from one of these reports adequately sums up the collective assessment:

> *"The state is weak in many areas. Services—such as acute and long-term care for individuals with co-occurring disorders—are scarce or non-existent in small towns and rural areas. Involuntary commitments at the two state hospitals continue to increase because of the lack of community treatment services and lack of supported housing. The hospitals are overcrowded, with forensic patients occupying many of the state hospital beds. Some areas have long waiting lists for services. Mountain Health Choices is a disaster. It has set the state back in meeting public health needs, financially destabilized providers, and deprived some consumers of needed services in a state that already suffered from uneven access to care and a lack of evidence-based practices. West Virginia faces many challenges: poverty, the rural nature of the state, and lack of investment in community mental health. Sadly, its leadership example in the face of crisis has been primarily to demonstrate what poor, rural states should not do."*[43]

Although somewhat dated, little has changed since these findings, as well as those from many of the other reports were first published: Mountain Health Choices, for example has been abandoned but the majority of providers still face financial instability; the census at state hospitals continues to exceed capacity; access to care, especially in rural areas remains limited; mistrust of state leadership has increased along with doubts regarding their ability to successfully move the system forward. Compounding these unresolved system failures, the state has yet to develop a comprehensive state wide behavioral health plan.

The following is a list of those reports reviewed as part of this project. A brief annotation and a summary of significant findings and recommendations of each are provided in Appendix 7.

[43] "NAMI Grading the States 2009" National Alliance on Mental Illness, page 153. Available at http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459

1. **"Transforming Behavioral Healthcare in West Virginia" (7/2/2007). Ron Manderscheid, PhD of Constella Group, LLC and Johns Hopkins University—PowerPoint Presentation.**

2. **"Proposed Redesign of West Virginia's Behavioral Health Service System—Final Report." (December, 2006). Public Consulting Group. Presented to State of WV Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities.**

3. **"Integrated Funding Analysis of Mental Health and Substance Use in West Virginia: Joint Meeting of WV Comprehensive Behavioral Health Commission/Advisory Board" by Public Consulting Group (March 13, 2007).**

4. **"Following the rules: A report on Federal Rules and state actions to cover community mental health services under Medicaid." (2008). Bazelon Center. Retrieved from www.bazelon.org/pdf/followingrules.pdf**

5. **Synopsis of Current Recommendations for Mental Health and Substance Abuse Services in West Virginia: With a Blueprint for Transformation" (August, 2008)—West Virginia Mental Health Planning Council.**

6. **"Crossroads: Creating a System of Care for Adults with Mental Illness or Co-occurring Disorders." (2009). West Virginia's Comprehensive Community Mental Health Centers.**

7. **"NAMI Grading the States 2006." National Alliance on Mental Illness. Retrieved from http://www.nami.org/Content/NavigationMenu/Grading_the_States/Full_Report/GTS06_final.pdf**

8. **"NAMI Grading the States 2009." National Alliance on Mental Illness. Retrieved from http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459**

9. **"Realizing Our Potential: Transforming West Virginia's Behavioral Health System" (May 21, 2009). Task Force on Behavioral Health Services Preliminary Report.—WV Comprehensive Behavioral Health Commission.**

10. **Laurie A. Helgoe (6/18/10). "Behavioral Health for the Vulnerable: Can HMOs Deliver?"—For the WV Behavioral Healthcare Providers Association**

IX. SUMMARY AND RECOMMENDATIONS RELATED TO STAKEHOLDER FEEDBACK

The findings and observations identified during the interview and survey process might well be categorized by some as largely "opinion" and therefore somewhat subjective. However, they contain significant information and clearly represent the collective experiences of both providers and consumers who are attempting to deal with the realities of West Virginia's deteriorating mental health system of care. Although some differences of opinion were identified, the majority of those interviewed and/or those respondents to the survey agree that the current system of care is extremely weak and void of sufficient resources to effectively meet the needs of consumers. In addition, many of their concerns and specific criticisms of the existing Medicaid authorization and reimbursement process were validated during CSM's review and comparison of the state's UM Guidelines. The following is a brief summary of these findings and observations. Although arranged by category, there is clear synergy and interconnectedness that is crucial to both understanding the current situation, as well as ultimately the development of a systematic remediation plan.

A. Findings

1. Continuum of Care Issues

All stakeholders agreed that the absence of a full continuum of care was a major issue facing both providers and consumers alike. Part of this failure was largely attributed to the elimination of certain programming options following the Federal Disallowance, including group homes and other residential services. However, the inability to consistently obtain authorization from APS for certain approved services including day-treatment and targeted case management has also effectively minimized the care available to patients. Other areas of concern include the lack of CSU programming in all regions capable of caring for many of those with acute-care problems. The lack of access to ACT programming or similarly aggressive treatment interventions statewide was also repeatedly mentioned. Since many of these "core" services are critical for maintaining the most acute patients in the community, CSM is not surprised that there has been a measurable rise in state hospital admissions and over-census problems for the past decade. The rise in forensic patients at the state hospitals might also, at least in part, be traced the lack of a full continuum of care. It was reported that judges are frequently unwilling to discharge some patients because of the lack of certain community services to serve them adequately.

Recent service enhancements that have been mandated through the "Agreed Order," are seen as steps in the right direction. However, these programming initiatives appear to lack sustainable funding and are not designed to provide these key services statewide. Perhaps more alarming is the fact that these service enhancements are in response to a judicial process rather than the logical outcome of a comprehensive planning process that has consensus from all stakeholders.

2. APS and the Service Authorization Process

The provider system clearly acknowledges the competent and professional role APS plays in the current Medicaid reimbursement system. Both parties have developed an effective working relationship largely devoid of significant day-to-day disagreements. However, that assessment is somewhat misleading. Providers are adamant that APS, in response to pressures from the state to reduce spending and avoid another disallowance, has effectively reduced access to certain services. Documentation requirements for certain service codes is perceived as being unrealistic or simply cost prohibitive while the medical necessity guidelines for other services are too rigidly interpreted. In response, the providers report that they have simply "learned" what will and what will not be approved and largely limit their request to those parameters. Results from CSM's review and comparison of the state's UM guidelines and how they have been interpreted largely support the provider's point of view. Unfortunately, the obvious impact on patient care is dramatic; patients are being denied access to critical services that would better enable them to be treated in the community.

3. Funding and Reimbursement Concerns

With few exceptions, the Comprehensives are facing significant financial challenges. The combination of insufficient reimbursement for the majority of service codes and the inability to consistently obtain authorization from APS for other key services has compounded their escalating costs of providing care to consumers. Despite implementing various cost saving steps (i.e., reducing the professional level of staff, ending various programs and services, foregoing raises and cost-of-living increases, reducing staff, etc.) most expressed doubts regarding their ability to effectively continue to provide quality care to those in need. It is not surprising that the perceived negative impact of a fully managed system of care including incentives to further reduce Medicaid costs has raised such unanimous concern among the leadership of the provider system.

4. Proposed MCO Implementation

Many adults with serious and persistent mental illness also have chronic medical conditions. Large numbers of these patients die twenty or more years earlier than others in their age cohort who do not have similar mental health issues. At the time of this report, West Virginia was in the process of implementing contracts with managed care organizations to manage the integration of primary and behavioral healthcare. Current research supports this model for integration, especially when provided in a behavioral healthcare setting that embraces the principles of wellness and recovery.[44] In fact, as previously reported, some of the Comprehensives already have practical experience with this type of service integration on the local level. Unfortunately, the model of integration being proposed by West Virginia does not align with federally supported current research. In addition, two of the three MCO's have indicated that they will sub-contract the management of behavioral healthcare to another provider further diluting the stated

[44] For a review of this research, see the following: http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf

goal of "improved integration." Along with the anticipated increase in bureaucracy, it is not surprising that the majority of stakeholders question the state's motives for this initiative.

5. Recognition of Regional Differences

West Virginia is a diverse state encompassing both expansive rural areas and urban centers. This variance from one environment to another creates enormous challenges that the current system of care and especially the existing Medicaid reimbursement process does not adequately account for. Rural areas, for example, have none of the "economies of scale" afforded the more urban areas of the state dramatically affecting the nature of service delivery and its overall effectiveness. Housing options, transportation, patient population volumes, geographic and weather related barriers routinely limit the provision of clinical and support services to consumers. Combined with a non-flexible funding system these factors have largely threatened the financial stability of several Comprehensives and severely limited treatment services for consumers.

6. Provider and State Relations

Providers generally raised concerns regarding the quality and depth of leadership, as well as inadequate numbers of staff, at the state level. The lack of a historical perspective and a non-inclusive management approach which had repeatedly ignored the opinion of the provider system highlights their perception. The failure of Mountain Health Choices, the financial costs associated with the diversion hospital alternative and the proposed implementation of a fully managed system of care without first soliciting feedback from them, are just a few examples of what the providers see as the state's overall lack of a coherent vision. Although no one went so far as to describe the relationship as openly "adversarial," the current environment is clearly less then productive and few providers expressed any level of confidence in the current leadership's ability to successfully facilitate necessary changes to the system.

7. Need for a Current and Comprehensive State Plan

Repeatedly throughout this project CSM has seen evidence of a system that lacks direction, focus and a unified purpose consistent with a comprehensive state-wide plan. The system is perceived by the majority of stakeholders as fragmented, ineffective, and incapable of meeting the needs of the most fragile elements of society. The last plan of its kind was reportedly dated in the mid-1990s, and clearly predates the impact of the disallowance, system dissolution, changes in the funding stream, implementation of an ASO managed care system, and many of the principles of wellness and recovery. During the intervening years since the last plan was developed, numerous consultants and experts have been contracted by both state departments and community groups.[45] Committees and commissions have also been established and likewise charged with the responsibility of evaluating the system of care. Multiple reports have been written and lists of recommendations have been identified including the critical need to develop a

[45] See Appendix 7 for an annotated summary of these recent reports.

comprehensive state plan for behavioral health that has the consensus of all stakeholders. To date those recommendations have been unrealized and the system continues to struggle without clear direction.

B. Recommendations

The behavioral healthcare system in West Virginia is experiencing a prolonged crisis. Major providers are struggling financially while consumers, especially those in rural areas, are often unable to access a sufficient level of care to ensure their continued stability in the community. In the past decade new patient populations have emerged to further stretch the state's limited resources. State hospitals have been charged by the courts with the responsibility to manage a substantial cohort of forensic patients who require long-term institutionalization. There is also an expanding group of younger patients with significant co-occurring substance abuse and mental health disorders. These dually diagnosed individuals are characteristically treatment resistant, require repeated inpatient stays and typically have little or no insurance or other benefits. Management of the primary funding mechanism (Medicaid) unnecessarily limits access to certain core services while other key service components (i.e., residential, transportation and medication) are not adequately subsidized by state dollars. The relationship between state leadership and the provider base is strained and largely non-productive. In summary, the majority of stakeholders are frustrated and pessimistic about the system's lack of clear direction and capacity to improve going forward.

The need for the state to rapidly develop and formalize a comprehensive plan for behavioral health cannot be stressed enough. In lieu of one, the system will likely continue to be fragmented and reactive instead of proactively dealing with the historic causes of failure. Key elements of the plan should include:

- Provision of a full continuum of care that adequately accounts for existing barriers created by geographic, demographic and regional differences
- Adoption of Wellness and Recovery Principles along with evidence-based practice models
- Development of a comprehensive workforce development strategy to ensure that there are sufficient competent and knowledge personnel to staff these advanced services.
- Consider the development of a specialized facility for the management of forensic patients
- Inclusion of all stakeholders in both design and implementation
- Development of multi-faceted and sustainable funding strategies that appropriately maximizes the utilization of Medicaid funds, Federal Block Grants, dedicated state dollars and other funding sources
- Support for and continuing refinement of integration efforts between primary care and behavioral healthcare aligned with existing Federal initiatives, especially for those with severe and persistent mental health and co-occurring substance abuse problems

Specific areas for consideration during the plan development should include:

- Use of the 1915i Medicaid Plan Amendment option to provide specialized services and delivery options (e.g., intensive case management services and CSU programs in less populated areas)[46] [47]
- Improving the capability of all providers of CSU services to facilitate the treatment of a more acute patient population and to provide an alternative to the current diversion hospital program.
  - Explore the use and/or development of other community-based services to keep individuals in the community, such as respite, ambulatory detox, mobile crisis, etc.
- Explore the development of "Health Homes" designed to improve primary care and mental health service integration while taking advantage of the two-year 90% federal match.[48]
- Improve communication and participation of stakeholders statewide through the exploration of regional and tele-conferencing methods
- Ensure that the specialized service needs of the "aging-in" population are adequately accounting for in any plan design
- Strengthen the role of Care Coordinators in the system
- Consider the use of "individualized" state grants and/or other creative funding mechanisms to support the discharge of difficult to place individuals from the state hospital.[49]

CONCLUSION

In recent years there have been many advances in approaches to mental health services on a national level. For example, in its report "*Achieving the Promise: Transforming Mental Health Care in America*", The President's New Freedom Commission on Mental Health formed by President George W. Bush identified the need to reshape the nation's mental health system. Among other findings and recommendations, the commission identified two principles for successful transformation of the system:

First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers not oriented to the requirements of bureaucracies.
Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.[50]

[46] http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Medicaid/The_Home_and_Community_Based_Option_final.pdf
[47] http://www.bazelon.org/LinkClick.aspx?fileticket=XI9rDQNLeRc%3d&tabid=242
[48] http://www.samhsa.gov/samhsaNewsletter/Volume_18_Number_5/SeptemberOctober2010.pdf
[49] CSM understands that proposals similar to this have recently been made.

The commission also specified that "More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs. Treatment and services that are based on proven effectiveness and consumer preference — not just on tradition or outmoded regulations — must be the basis for reimbursements."[51]

In 2006, the Substance Abuse and Mental Health Services Administrative released its national consensus statement on the ten fundamental components of mental health recovery which includes[52]:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer support
- Respect
- Personal Responsibility
- Hope

These principles are not just words on paper. To truly embrace them requires a fundamental shift in how mental health services are configured and delivered. No longer is treatment something that is imposed on consumers by professionals and administrators, but a collaborative process that puts the consumer at the very center of a meaningful planning and recovery process.

In addition, in 2009, President Obama announced the "Year of Community Living" to mark the 10th anniversary of the *Olmstead v. L.C.* decision, in which the U.S. Supreme Court affirmed a State's obligation to serve individuals in the most integrated setting appropriate to their needs. In the *Olmstead* decision, the Court held that the unjustified institutional isolation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act.[53] To support this initiative, the Department of Health and Human Services (HHS) announced the Community Living Initiative. As part of the initiative, HHS is working with several Federal agencies, including the Centers for Medicare & Medicaid Services (CMS), to implement solutions that address barriers to community living for individuals with disabilities (including mental illness) and older Americans.

CMS supports the transformation in other ways as well. States have considerable latitude in shaping their Medicaid programs. While each state's Medicaid program must meet mandatory

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[50] "*Achieving the Promise: Transforming Mental Health Care in America*", The President's New Freedom Commission on Mental Health, page 11, July 22, 2003.
[51] "*Achieving the Promise: Transforming Mental Health Care in America*", The President's New Freedom Commission on Mental Health, pages 9, 12, July 22, 2003.
[52] http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf
[53] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

Federal requirements, including covering essential health service, and serving core eligibility groups, Federal law and regulations give States many options to customize the design of their service delivery system. In addition, CMS also provides the flexibility to address the unique needs of patients and families through various waivers and demonstration projects. CMS encourages this approach and offers technical assistance to states regarding the design and operation of their Medicaid programs.

In direct contradiction to these mandates and initiatives, West Virginia's behavioral health system is heavily oriented toward regulatory compliance, promotes involuntary inpatient confinement, focuses on managing discreet "episodes of care" and symptom management rather than individualized treatment and supports that promote recovery and community tenure for persons with mental illness. A more preventative or proactive approach is needed. Utilization management (UM) guidelines are just one component of the system that contributes to the lack of comprehensive services that support recovery and community living. Compared to other states reviewed the UM guidelines are more focused on why a person is ineligible to receive services rather than how services that assist consumers to live in the community and lead meaningful lives can be tailored to individual needs. While regulatory compliance is important and necessary, it should not be the primary focus of UM. Effective UM programs promote access to appropriate services based on an individual's needs and strengths and result in optimal outcomes for consumers, while at the same time managing utilization and costs. This means that authorization decisions take into consideration not only an individual's immediate treatment needs, but long-term strengths, needs, choices and goals as well. In practice, service authorizations may be for shorter or longer time periods and for different service mixes depending upon where a consumer is at in his or her recovery process. In other words, persons with similar diagnoses and symptoms may require different services due to their unique circumstances. While West Virginia's guidelines for rehabilitation services do include service descriptions that incorporate "interventions which are intended to provide support to the member in order to maintain or enhance levels of functioning"[54], in practice authorizations are heavily focused on demonstrated improvement in functioning rather than acknowledgement that a service may be required to maintain level of functioning, increase community tenure, and reduce the need for more restrictive levels of care. If justified through documentation that a consumer is likely to deteriorate without continued interventions the service should be authorized.

Another critical gap in the West Virginia system is limited service capacity compared to other states. The state has made some progress in this area with the revision of guidelines and processes for assertive community treatment, which is an evidence-based practice and will provide a valuable service for consumers who have a serious mental illness. However, as in other states such as Nebraska, the service will likely have limited use in rural areas due to limited resources to meet the model's staffing and administrative requirements. More importantly, there seems to be a lack of a comprehensive plan and philosophy for advancing West Virginia's mental health delivery system. The long standing objective has been to avoid disallowances. Although this is important, it should not be the main objective of the system. Additionally, "plugging holes" in the system through development of a service here or there, revising guidelines, or providing one time sources of funding is ineffective in providing a comprehensive continuum of care that is sustainable.

[54]Behavioral Health Rehabilitation Services Manual, West Virginia Bureau for Medical Services, page 15.

Other states have made significant strides in system transformation. For example, Iowa has been successful in increasing access to services, reducing inpatient lengths of stay and expanding the array of available services for Medicaid recipients by developing recovery-driven services and UM guidelines, in a cost-effective manner.[55] The present weaknesses in the West Virginia system are the result of a decade of deficiencies in planning and vision. A comprehensive approach and plan for transformation is needed that encompasses all aspects of the system.

In conclusion, CSM began our process with the purpose of reviewing Medicaid utilization management and its impact on the West Virginia system of behavioral healthcare. As detailed in this report, our findings support the conclusion that the design and administration of the Medicaid mental health services plan has evolved to become unnecessarily limited and restrictive. In brief, despite recent progress, APS and the Medicaid system fall short of the direction given by Judge Louis H. Bloom in the Agreed Order to "maximize availability of those [clinic and rehabilitation] services within the federal regulations."[56] However, it should not be inferred that the shortcomings in Medicaid are the primary ***cause*** of the problems facing the community behavioral health system of care. Medicaid's limitations are more realistically an outgrowth or a symptom of the fundamental flaws inherent in the behavioral health system. In the past decade many states have adopted progressive approaches to supporting the emotional health and well-being of individuals living with serious and persistent mental illnesses and/or addictions. In those states, Medicaid performs the function for which it is best suited, being one of the important reimbursement mechanisms which support the transformation of the system of care. Changes in Medicaid must be directed by an overarching planning process.

[55] http://www.dhs.state.ia.us/rts/Lib_Train/TCM/09-13-07/Magellan%20Overview.pdf
[56] Agreed Order, Paragraph 4, (b).

Appendix 1—Original Proposal Overview

PROPOSAL TO WEST VIRGINIA FOR UTILIZATION MANAGEMENT REVIEW CONSULTATION

I. INTRODUCTION

A. Salient Background of Project

The state of West Virginia has requested a "Utilization Management Review" of its Guidelines that govern reimbursement for community behavioral health services in the context of helping the parties in the E.H., et al v. Khan Matin, et al. (Hartley) case. It has enumerated a series of objectives that are addressed throughout this proposal. Clinical Services Management, P.C. has the knowledge and experience to assist the state in meeting these objectives. This coupled with our flexible pricing approach makes us uniquely qualified to conduct the Utilization Management (UM) Review Project Activities.

B. Description of Clinical Services Management, P.C.

Clinical Services Management, P.C. (CSM) is a behavioral healthcare consulting and management organization with extensive experience in contract management, strategic planning, and systems analysis for state mental health and developmental disabilities authorities and providers of hospital and community-based behavioral healthcare services. In the past thirty years, CSM, its principals, employees, and consultants have been responsible for developing, implementing, operating and evaluating behavioral health services throughout the continuum of care, including:

- Clinical and Provider Network design, implementation, and management of state and national behavioral health managed care programs
- Consultation to State HCBS programs for individuals needing Home and Community Based services for disabilities including mental health, developmental disabilities, traumatic brain injury, dual diagnoses, physical disability in adults from 18-65 as well as disabilities related to aging.
- Consultation and training for community providers of services to individuals with disabilities requiring mental health, substance abuse, developmental disabilities, aging and other health and support services to improve quality of care.
- Voluntary/Involuntary, Adult, Adolescent and Children Inpatient Units
- Psychiatric Emergency/Screening and Mobile Outreach Services

- Adult and Adolescent Residential Services
- Acute and Rehabilitative Partial Hospital Programs
- Traditional and Managed Care-Focused Outpatient Services
- Employee Assistance Programs
- State Licensing, Regulatory, and Accreditation Oversight and Consultation

In addition, members of the CSM Team possess specific expertise and experience with direct relevance to many of the key issues and decisions being considered by West Virginia.

CSM TEAM MEMBERS

The following list provides a brief overview of CSM staff and consultants who will be involved in the project. These individuals will be immediately available to assist throughout the length of the engagement.

Team Member	Primary Roles	Related Experience
Peter Pastras, LCSW	Project Coordinator; field research and report development	Extensive healthcare administrative and operational experience; designed and implemented numerous assessment and strategic projects; lead consultant in numerous regional or statewide systems evaluation in the disabilities field
Charles Higgins, M.Div	Field research and report development	Extensive healthcare administrative and operational experience; designed and implemented numerous assessment and strategic projects; consultant in numerous regional or statewide systems evaluation in the disabilities field
Julie Bigelow, RN	Research Director: Perform comparison of UM guidelines, research federal and state laws and report development	Extensive experience in large national and statewide managed behavioral health care contracts including UM and provider networks.
Jeanne Wurmser, PhD	Survey design; data analysis and field research	Extensive healthcare administrative and operational experience; consultation to New Jersey Division of Developmental Disabilities & Division of Aging & Community Services on Home

Team Member	Primary Roles	Related Experience
		and Community-Based Services (HCBS) Waivers and CMS grant application/implementation
Craig Blum, PhD	Field Research Coordinator; survey design; and report development.	Former Joint Commission Surveyor, NJ Operations Manager for nation-wide managed care organization, and CSM Corporate Vice President Quality Improvement; Lead or research consultant in numerous regional or statewide systems evaluation in the disabilities field
Don Fowls, MD	Provide psychiatric consultation and analysis of UM guidelines	Former Chief Medical Officer for national and state behavioral health managed care organizations. Development of UM guidelines, clinical and quality improvement systems. Value Options, Triad Healthcare, and Comp Care consultant reviewing UM guidelines, focusing on best-practice standards in the field/industry.

CSM has led or participated in the performance of multiple program evaluations and needs assessments for entire states, as well as separate organizations providing services to individuals with mental illness, substance abuse, developmental disabilities and acquired brain injuries.

A more detailed explanation of the proposed project and the identification of outcomes are outlined below.

II. PROPOSAL OUTLINE

A. Overview of Project

CSM's proposed approach consists of the components listed below:

- Phase I: Project Launch
- Phase II: Data Collection
- Phase III: Data Analysis and Preliminary Review with West Virginia
- Phase IV: Report

We are prepared to start within approximately two to four weeks of the finalizing of a consultative agreement and work intensively with the liaison (or Project Leadership Team) appointed by the Office of the Monitor. A narrative description of our proposed approach is provided below which delineates the various analyses to be performed and outcomes associated with each activity. We estimate that the project outlined below will require approximately 12 to 16 weeks inclusive of the various phases of data collection, analysis and report development.

B. Phase I: Project Launch

During the Project Launch Phase, CSM will collaborate with Office of the Monitor to facilitate the initiation of the project. Specific tasks to be included in this activity are:

- Designation of Project Liaison or Project Leadership Group
- Finalize project timeline
- Set up "Launch Meeting"
- Identification of reporting structures for oversight of contract
- Development of meeting schedule and accountability structures as necessary
- Review and approve project implementation plans and subsequent modifications
- Define data and information requirements
- Identify individuals and groups to be interviewed. This process will focus on all identified significant stakeholders including (but not necessarily limited to) consumers, advocates, free standing community providers and hospitals

C. Phase II: Data Collection

The following are the West Virginia consultation objectives with an outline of the steps that CSM will take to review them:

Objective 1: *Review UM Guidelines that govern reimbursement for community behavioral health services (currently utilized by APS Healthcare) against other comparable guidelines for similar states to determine how the West Virginia guidelines can be tailored to satisfy their purpose more appropriately.*

Consultation Plan. A representative sample of three states will be selected for review. Guidelines and other materials will be obtained from these states and a crosswalk will be developed to provide for a comparison and evaluation of West Virginia's UM Guidelines versus other relevant states' guidelines.

Steps:

a. Gain access to West Virginia's UM Guidelines
b. Determine other states to review against. In making this determination factors such as the following will be considered:

- West Virginia's preference as to other states to be reviewed

- Populations served
- State demographics
- Types of services covered
- Whether or not vendor is at-risk or program is an Administrative Services Organization similar to West Virginia
- Whether program is state-wide or regionally/county-based
- Access issues related to rural areas
- Comparison of other vendors: i.e., Magellan, ValueOptions
- Relationship of individual's assignment to Basic or Enhanced benefit plan under Mountain Health Choices or assignment to traditional Medicaid plan on APS authorizations
- How providers are reimbursed, i.e., fee-for-service, case rate, subcapitation

Examples of state Medicaid UM guidelines that might be considered are the Pennsylvania HealthChoices, Maryland ASO, and the Iowa Plan for Behavioral Health guidelines. There are similarities and differences between these programs as compared to West Virginia. For example, the Pennsylvania programs are county or regionally based and managed by various local and national vendors. However, the UM guidelines, known as Appendix T are required to be used by all vendors statewide. Each vendor may also develop supplemental guidelines for additional services with county and state approval. Unlike West Virginia, HealthChoices programs are at-risk rather than ASO. The Maryland Public Mental Health System program is a statewide ASO contract. The contract was awarded to ValueOptions earlier this year and went live in September. As such, the new vendor's ASO is not as mature as West Virginia's and some guidelines are under development. The Iowa Plan for Behavioral Health has been evaluated by Mercer and others to be a national leader and model program. The program is managed by Magellan Health Services and has been successful in expanding services such as Assertive Community Treatment, Self-Directed Care, and others, as well as providing easier access to services in rural areas of the state. The vendor receives a fixed administrative fee and savings related to care costs are reinvested in the program.

These are just a few examples of factors to be considered in selecting state guidelines to be reviewed. The final determination will be made in collaboration with the Office of the Monitor or other designated decision making group assigned to this project.

c. The review and comparison of the UM guidelines by state will include at a minimum the following elements:

- Service type (comparable services in other states if not the same)

- Diagnostic criteria
- Functional status criteria
- Coordination of care requirements
- Review frequency
- Documentation requirements

Since UM guidelines vary from state to state, coordination of care, review frequency and documentation requirements may or may not be included in the guidelines themselves. However, these requirements are typically outlined in provider manuals, supplemental documents, and forms. CSM will reference these documents as needed as part of its review and crosswalk. Results of the review and comparison will be presented in a written report and will include the crosswalk as well as a narrative description of the methodology used and findings.

Projected Timeframe. Approximately 220 Hours

Objective 2: *Review the guidelines against applicable federal and state Medicaid law and regulations to determine the flexibility and limits to altering the guidelines in order to increase access to services.*

Consultation Plan. Federal and state law and regulations will be obtained for expert review and analysis. Appropriate state and other regulators will be interviewed for additional insight and information to formulate possible mechanisms to increase access to services.

Steps:

a. Research federal and state laws and regulations including those related to UM, denial, and appeal parameters:
   - The Code of Federal Regulations (CFRs) with specific focus on relevant parts of CFR Title 42
   - Chapters and Articles of the West Virginia Code, for example Chapters 9, 27, and other related Chapters and Articles

b. Generate written report of findings and recommendations

Projected Timeframe. Approximately 60 Hours

Objective 3: *Gain input from a variety of behavioral health care providers who seek reimbursement under the guidelines to evaluate considerations of (i) too much discretion under the guidelines, which may have been used to arbitrarily increase denials through informal policy of the implementing authority (APS); (ii) guidelines that are too restrictive, thereby requiring denials for services that are appropriate and allowed under Medicaid law and regulations; and (iii) guidelines that are being misinterpreted or misapplied by the*

implementing authority [By way of example, some issues that have been previously noted by providers are:

(1) The possibility of excessive documentation requirement for admission and retention in basic skills training and day treatment to show that a person is improving or preserving functionality each 90 days;

(2) The possibility of too much ambiguity in the language allowing denials for clinical exclusions for basic skills training; and

(3) The possibility of inappropriate denials of qualifying individuals with bipolar disorder or depression from basic living skills and day treatment, even though the guidelines generally state that all Axis I diagnoses qualify.]

Consultation Plan. A variety of behavioral health providers will be interviewed and/or contacted to provide information and perceptions concerning the existing nature of how the guidelines are administered in terms of arbitrariness of denials, restrictiveness of service authorization, and misinterpretation or misapplication of decisions. CSM will have direct contact with all relevant providers, including the behavioral health care providers in the APS network, and provider or professional groups (e.g., the West Virginia Behavioral Health Providers Association).

Steps:

a. Identify target providers and finalize format. The format will include focus groups, individual provider interviews and a questionnaire/survey. CSM has utilized an internet- or web-based technology to conduct state-wide surveys that maximize reach with minimum cost and intrusiveness. In the process of survey design, face-to-face, telephonic interviews and focus groups will be used with key stakeholders. The preparatory interviews are especially important for the purpose of gaining perspective on relevant issues to include in the more broad-based survey process using the web-based technology.[57]

b. Plan and implement a series of four (4) structured provider meetings across the state will allow for input by professionals providing services within the system. We would anticipate that these should happen in Charleston, Morgantown, Martinsburg, and Wheeler, although we will collaborate with the Office of the Monitor to determine the best settings.

c. Develop relevant questions in order to understand the providers' experience with APS, such as:
   - Have you received training on the UM guidelines?
   - Do you believe you have a working knowledge of/know how to apply the guidelines?
   - Do you have access to clinical consultation at APS if you have questions about the guidelines?

[57]To see one of our surveys, follow this link: http://www.surveymonkey.com/s.aspx?PREVIEW_MODE=DO_NOT_USE_THIS_LINK_FOR_COLLECTION&sm=HZ7rwNGC%2fDmTuWg5%2fwHZExqKSvH4Q2SFW%2fKHbt7xQ3g%3d

- Have you ever has a denial from APS? If yes, for what service type? How many denials have you had in the last year? Were you informed of the specific UM guideline(s) that were not met? Were you informed of appeal rights and procedures? Did you file an appeal? If yes, what was the outcome (denial upheld, overturned, modified)?
- Do you know how to file a complaint with APS? Have you ever filed a complaint? How many in the last year? Nature of complaint(s) (Note: could include list of typical complaints along with an "other" category for easy tallying). Outcome?
- In your experience, are APS reviewers knowledgeable about the guidelines?
- Do you work with different reviewers at APS? If yes, in your experience, do they apply the guidelines consistently?
- How has your agency been impacted by the redesign of Medicaid under Mountain Health Choices?
- Is there a clear process for you to find out if individuals presenting for services are covered in the traditional Medicaid program or in the Basic or Enhanced plan under Mountain Health Choices?

Projected Timeframe. Approximately 80 Hours

Objective 4: *Interview advocates and consumers in order to identify services that are most lacking and necessary in their view; determine whether these same services are being denied under the guidelines; and make a recommendation as to how guidelines could be restructured to allow reimbursement for the proposed services.*

Consultation Plan. It will be important to gather information from consumers, their families/significant others, as well as consumer advocates on their perceptions about needed services and their availability, how the process of service approval is working, their experience with service denial, and other thoughts about the nature of the service-delivery system.

Steps:

a. Determine target groups including advocacy groups (e.g., West Virginia Mental Health Consumers Association, NAMI West Virginia), and individual consumers and families/significant others.

b. Develop format for interviews including a combination of one-on one-interviews, focus groups and open forums. In-person interviews, telephone interviews (including a 1-800 number that individuals and family members can access), mailed surveys, use of web-based systems (as noted above for selected individuals/groups), and other mechanisms will be considered to maximize participation and ensure a substantial sample of consumers and

consumer-connected stakeholders. Surveys will be tailored to the type of individuals and/or groups that are identified. The following options are contemplated:

- For advocacy groups, it is anticipated that an important mechanism for data collection will be the web-based survey tool, which will allow for maximum coverage across the state from all relevant groups and their chapters. This will also allow for some standardization of questions and improve comparability. Telephonic interviews with leaders will also be completed to gain some general ideas of relevant issues in the state, and some in-person interviews will be completed.

- For consumers, a number of approaches are planned, as follows:
  - A series of four (4) structured public meetings across the state will allow for input by individuals being served by the system, as well as by their families/significant others. We would anticipate that these should happen in Charleston, Morgantown, Martinsburg, and Wheeler, although we will collaborate with the Office of the Monitor to determine the best settings.
  - A structured survey tool will be sent to a sample drawn from consumers of the system. This would be more representative, assuming a reasonable response rate. It might limit the information we could obtain from families and significant others, but individuals could be asked to give a survey to their families/significant others for their input. These would come with a stamped return envelope. Individuals would also be given a 1-800 number to call to provide the information or given a web-link for those with access to a computer.

c. Develop questions related to access to services to include in surveys/interviews, such as:

- Do you know what services are available?
- Do you know who is eligible for services and under what circumstances?
- Are you familiar with how to access services?
- Have you ever used services? If yes, what kind of services? (Note: list services covered in the guidelines)
- Have you or your family member ever been denied services by APS? If yes, do you know the reason for the denial? Did you or your provider file an appeal? Outcome?
- Have you or your family member been unable to obtain services in your community even though services were authorized?
- What types of services should be developed or expanded?
- Has access to services changed as a result of WEST VIRGINIA's redesign of its Medicaid plan?

- What changes have you seen for individuals with behavioral health, TBI, developmental disabilities or dual diagnoses under Mountain Health Choices?

Projected Timeframe. Approximately 80 Hours

D. Phase III: Data Analysis and Preliminary Review with West Virginia

The information and data collected in the previous phase will be reviewed and analyzed by the consulting team using valid and reliable methodologies. A preliminary review of the findings with the Project Liaison or Project Management Team is envisioned in order to ensure accuracy of findings, as well as to address any areas to be further explored or refined. This would be held through a telephonic conference call(s). The timing and specific nature of this phase will be developed and refined in West Virginia after the initiation of the project.

E. Phase IV: Final Report Generation

Objective 5: *Issue a comprehensive report with recommendations as to how the guidelines can be restructured under current legal constraints in order to increase access to services with attention to (i) eliminating discretion to deny appropriate services by clarifying the specific services that must be reimbursed and (ii) changing the any unduly restrictive guidelines to allow reimbursement for all additional services (with particular attention to those services identified as lacking by providers, advocates, and consumers) that may be reimbursed under applicable state and federal law.*

Consultation Plan. The culmination of the preceding steps will be the development of a comprehensive written report, as follows:

Steps:

a. Generate a written report that summarizes all of the above with graphics showing results
b. Include recommendations and rationale for changing/enhancing guidelines and methodology.
c. Recommendations will be based on findings with an eye toward developing/expanding evidence-based practices that promote recovery and resiliency and incorporating clinical practice guidelines if appropriate
d. Recommendations might also include:

- Further review of APS internal clinical operations, any reports from internal and external audits, results of inter-rater reliability studies, or other related documents.
- Additional provider training on the guidelines and covered services
- Changes/enhancements to APS policy and procedure
- Design and implementation of quality improvement and/or performance improvement activities
- Revisions in Medicaid Plan (Mountain Health Choices) that could improve access for individuals needing behavioral healthcare services.

Projected Timeframe. Approximately 90 Hours

APPENDIXES 2-5 - INTRODUCTION

Introduction to UM Guideline Tables
Appendixes 2-5

Tables are intended to provide an overview of utilization management guidelines for each state related to adult clinic, rehabilitation option, and targeted case management services. Guidelines for other behavioral services and guidelines specifically related to children and adolescents are excluded.

All states include exclusion and discharge criteria for each service. These are not included in the tables as they are very similar across all states and services and can be summarized as:

Exclusion criteria:

- Member is not a member of target population for a particular service
- Member does not meet diagnostic criteria
- Member does meet age criteria
- Member's physical or mental impairments prevent participation in service
- Service cannot be provided concurrently with another service
- Intensity, frequency, and type of services are not appropriate for the member's age and functional level
- Service cannot be provided for a primary physical health condition

Discharge criteria:

- Member/family choice or request to terminate service
- Treatment goals have been met or substantially met
- Need for more or less restrictive levels of services
- Member unwilling or unable to participate in treatment/services/activities
- Lack of reasonable expectation for improvement

Member relocated to another state/geographic area

Appendix 2—UM Guidelines for West Virginia

Utilization Management Guideline Overview

Code	Service/Requirements	West Virginia
H2011	**Crisis Intervention**	**Core-Tier I**
	Diagnostic Criteria	Known or suspected behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: TX at lower LOC has been tried or seriously considered **and** Acute or severe psychiatric signs & symptoms **and** Member has insufficient or severely limited resources or skills to cope with immediate crisis, **and** Lack of judgment &/or impulse control &/or cognitive/perceptual abilities **and** Requires unscheduled face-to-face visit **or** Risk to self, others, or property. Inpatient care not required. Continued stay: Service may be used at various points in course of TX & recovery, however, each intervention is intended to be a discreet time-limited service for stabilization & transition to appropriate LOC. Other: Not be used as emergency response to situations such as running out of medication or housing problems.
	Coordination of Care Requirements	Reference to using TCM services to refer & link to other services
	Authorization/Review Frequency	Tier 1 data submission for 16 units/30 days. Unit=15 minutes. Tier 1 data submission for additional units after 30 days by provider previously using benefit for same consumer. Another request required for any provider to exceed limit of 16 units/30 days for utilization review purposes or if service is provided to address a new crisis episode.
	Documentation Requirements	Summary of events leading to crisis, interventions, outcome, times, dates, place of service, qualified staff signature. Physician/licensed psychologist/physician assistant/nurse practitioner review w/in 72 hrs., review start/stop times, follow-up recommendations, whether current TX plan can be maintained or needs modification.
H0031	**Mental Health Assessment by a Non-Physician**	
	Diagnostic Criteria	Known or suspected behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Member has just entered system, **or** WV DHHR request, **or** Assessment needed to meet state requirements to authorize Medicaid services &/or evaluate current TX plan. Continued stay: Need for assessment due to change in clinical/functional status. WV DHHR request Reassessment needed to meet state requirements to authorize Medicaid services &/or evaluate current TX plan.

Code	Service/Requirements	West Virginia
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 1 data submission for 6 events/yr., 6 units for 1 yr. from date of initial service. Unit=Event. Tier 1 data submission for additional units after 1 yr. for provider previously using benefit for same member, Tier 2 data required to exceed 6 units/yr.
	Documentation Requirements	Completed evaluation, signature, place, date, & amount of time spent providing service, start/stop times. Description of need for additional units for Tier 2 requests.
T1023HE	**Screening by Licensed Psychologist**	
	Diagnostic Criteria	Known or suspected behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Initial screening/intake indicates need for additional information **or** Member's situation/functioning has changed in such a way that prior assessments are inadequate, **or** Brief psychological required to render/confirm DX, evaluation required by the court, or evaluation in metal hygiene commitment proceedings. Continued stay: None. Other: Each intervention intended to be discreet, time-limited service used to direct member to appropriate LOC & service. Psychologist under supervision for licensure may perform this service.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 1 data submission for 1 unit/184 days. Unit=Event/session. Tier 1 data submission for additional units after 184 days for provider previously using benefit for same member. Tier 2 data required to exceed 1 unit/184 days. 1 additional unit can be approved.
	Documentation Requirements	Completed evaluation, signed by licensed psychologist, place, date, amount of time spent providing service, evidence of provision of results to appropriate parties. Description of need for additional units for Tier 2 requests.
96101	**Psychological Testing with Interpretation and Report**	
	Diagnostic Criteria	Known or suspected behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Known or suspected behavioral health DX **or** Testing or evaluation required for specific purpose **or** Required to make specific recommendations re: additional TX or services required. Continued stay: None. Other: Each intervention intended to be discreet, time-limited service used to direct member to appropriate LOC & service. Psychologist under supervision for licensure may perform this service.
	Coordination of Care	Not specified

Code	Service/Requirements	West Virginia
	Requirements	
	Authorization/Review Frequency	Tier 1 data submission for 4 hrs/yr. Unit=1 hr. Tier 1 data submission for additional units after 184 days for provider previously using benefit for same member, Tier 2 data required to exceed 4 units/yr.
	Documentation Requirements	Completed evaluation, purpose of testing, scoring & interpretation of testing, written report of findings & recommendations, signed by licensed psychologist, place, date, amount of time spent providing service, start/stop times, evidence of provision of results to appropriate parties. Description of need for additional units for Tier 2 requests.
96110	**Developmental Testing: Limited**	
	Diagnostic Criteria	Known or suspected developmental delay &/or behavioral health condition
	Admission, Continued Stay, & Other Service Criteria	Admission: Known or suspected developmental delay &/or behavioral health condition **or** Developmental testing or evaluation required for specific purpose **or** Required to make specific recommendations re: additional TX or services required. Continued stay: None Other: Each intervention intended to be discreet, time-limited service used to direct member to appropriate LOC & service. Psychologist under supervision for licensure may perform this service.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 1 data submission for 2 units/184 days. Unit=Event. Tier 1 data submission for additional units after 184 days for provider previously using benefit for same member, Tier 2 data required to exceed 2 units/ 184 days.
	Documentation Requirements	Completed evaluation, purpose, scoring & interpretation of testing & written report of findings & recommendations. Signed by licensed psychologist, place, date, evidence of provision of results to appropriate parties. Description of need for additional units for Tier 2 requests. If performed by other than psychologist (e.g. psychometrician) licensed psychologist must review, sign, date interpretation & report.
90801	**Psychiatric Diagnostic Interview Examination**	
	Diagnostic Criteria	Known or suspected behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Known or suspected behavioral health DX **and** Member is entering or reentering service system **or** Assessment needed due to change in clinical/functional status, Continued stay: Need for further assessment due to findings of initial evaluation &/or changes in functional status, **or** Reassessment needed to update/evaluate current TX plan. Other:

Code	Service/Requirements	West Virginia
		Physician assistant and nurse practitioner with psychiatric specialty may perform this service. Nurse practitioner without psychiatric specialty may perform this service under the supervision of a psychiatrist.
	Coordination of Care Requirements	May include communication with family members or other sources
	Authorization/Review Frequency	Tier 1 data submission for 2 sessions/yr. Unit=Session/Event. Tier 1 data submission for additional units after 1 yr. for provider previously using benefit for same member. To exceed annual limit, Tier 2 data submission required. 1 additional unit can be approved.
	Documentation Requirements	Completed evaluation, signed by psychiatrist, written record of findings & recommendations, place, date, evidence of provision of results to appropriate parties. Description of need for additional units for Tier 2 requests.
90862	**Pharmacological Management**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Psychiatrist has determined need for & prescribed psychotropic medication Continued stay: Member continues to meet admission criteria Other: Physician assistant and nurse practitioner with psychiatric specialty may perform this service. Nurse practitioner without psychiatric specialty may perform this service under the supervision of a psychiatrist.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 1 data submission for 12 sessions/184 days. Unit=Session/Event. Tier 1 data submission for additional units after 184 days for provider previously using benefit for same member. Tier 2 data submission required to exceed limit of 12 sessions/184 days. 1 additional unit approved if specific number of units not requested.
	Documentation Requirements	Activity note describing service provided, place, & date of service signed by psychiatrist. Description of need for additional units for Tier 2 requests. If provided as part of "low-end" service group, a TX strategy is sufficient to replace the MSP.
H2010	**Mental Health Comprehensive Medication Services**	
	Diagnostic Criteria	Severe and persistent mental illness (SPMI)
	Admission, Continued Stay, & Other Service Criteria	Admission: SPMI **and** Clozaril or other medication requiring intensive monitoring is prescribed & ordered by licensed physician **and** Comprehensive medication services are adjunctive to primary mental health services. Continued Stay: Continues to meet admission criteria Other: Nurse practitioner with psychiatric specialty may perform this service. Nurse practitioner without psychiatric specialty may

Code	Service/Requirements	West Virginia
		perform this service under the supervision of a psychiatrist.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 1 data submission for 24 units/92 days. Unit=15 minutes. Tier 1 data submission for additional units after 92 days for provider previously using benefit for same member. 24 units/92 days. Tier 2 data required to exceed limit of 24 units/92 days. Maximum of 8 additional units authorized if specific number of units not requested.
	Documentation Requirements	Physician's written medication order. Written note of assessment results completed by physician, physician assistant, RN, or nurse practitioner, results of lab work, current medication & dosage, authorized pharmacy, other relevant findings/recommendations, place, date, time of service & qualified staff signature. Documentation that member has been informed of risk & benefits of medication and that person administering medication is monitoring symptoms. Description of need for additional units for Tier 2 requests.
H0032	**Mental Health Service Plan by Non-Physician**	
	Diagnostic Criteria	Behavioral health condition requiring TX services
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health condition requiring TX services Continued stay: Behavioral health condition requiring TX services **or** 90 days have elapsed since TX plan completed & it must be reviewed **or** Significant TX juncture as necessitated by member's needs.
	Coordination of Care Requirements	Case manager responsible for coordinating TX planning process. Coordination with other agencies & resources needed to achieve TX goals.
	Authorization/Review Frequency	Tier 1 data submission for 16 units/30 days. Unit=15 minutes. Tier 1 data submission for additional units after 30 days for provider previously using benefit for same member. 16 units/30 days. Tier 2 data required to exceed limit of 16 units/30 days. Maximum of 4 additional units authorized if specific number of units not requested.
	Documentation Requirements	Documentation justifying presence & purpose for each staff participating in meeting. Completed TX plan or TX plan review, with signatures. Staff may participate for different lengths of time, depending on nature of their involvement & contribution to team process. Signatures must be original, in ink, legible, & include minutes attended. If member does not attend TX planning meeting, reason for member's absence must be documented. Legal guardian is required to attend TX planning and sign the plan for any person who has a court appointed guardian. Initial TX plan within 7 days of intake, MTP within 30 days. Includes criteria for TX plan content, TX plan review, mandatory team member participation.
H0032 AH	**Mental Health Service Plan Development by Non-Physician-Psychologist Participation**	
	Diagnostic Criteria	N/A

Code	Service/Requirements	West Virginia
	Admission, Continued Stay, & Other Service Criteria	Admission: The activity of licensed psychologist, under the Rehabilitation Option, participating in TX plan meetings, reviews, & approval of TX plans. TX plans must be reviewed, signed & approved within 72 hrs. of TX plan meetings. Licensed psychologist must be physically present & participate in all TX team meetings for members who meet any of the following: a) receive psychotropic medication b) have a diagnosis of major psychosis or major affective disorder c) have major medical problems in addition to major psychosis or major medications d) presence of licensed psychologist has been specifically requested by case manager or member. Continued stay: Licensed psychologist will continue to participate in TX team process including 90 day updates. Other: Supervised psychologist may perform this service with oversight by the supervising licensed psychologist.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 1 data submission for 1 unit/30 days. Unit =15 minutes. Tier 1 data submission for additional units after initial 30 day registration by provider previously utilizing benefit for same member. 1 unit/30 days. Tier 2 data submission required to exceed limit of 1 unit/30 days. Maximum of 1 additional unit authorized if specific number of units not requested.
	Documentation Requirements	For TX planning meetings & review & approval of TX plans, psychologist's signature on completed TX plan or 90 day update with date & duration of participation. Description of need for additional units for Tier 2 requests.
G9008	**Physician Coordinated Oversight Services**	
	Diagnostic Criteria	N/A
	Admission, Continued Stay, & Other Service Criteria	Admission: The activity of the physician, under the Rehabilitation/Clinic Option, participating in TX plan meetings, reviews, & approval of TX plans. TX plans must be reviewed, signed & approved within 72 hrs. of TX plan meetings. Physician must be physically present & participate in all TX team meetings for members who meet any of the following: a) receive psychotropic medication b) have a diagnosis of major psychosis or major affective disorder c) have major medical problems in addition to major psychosis or major medications d) presence of physician or licensed psychologist has been specifically requested by case manager or member. Continued stay: Physician will continue to participate in TX team process including 90 day updates. Other:

Code	Service/Requirements	West Virginia
		Nurse practitioner with psychiatric specialty may perform this service. Nurse practitioner without psychiatric specialty may perform this service under the supervision of a psychiatrist.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 1 data submission for 1 unit/30 days. Unit=15 minutes. Registration for additional units after 30 days by provider utilizing benefit for same member. 1 unit/30 days. Tier 2 data submission required to exceed limit of 1 unit/30 days.
	Documentation Requirements	For TX planning meetings & review & approval of TX plans, physician's signature on completed TX plan or 90 day update with date & duration of participation. Description of need for additional units for Tier 2 requests.
H0004 HO	**Behavioral Health Counseling, Professional, Individual**	**Core-Tier 1, Tier 2 Continued Stay**
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Intrapsychic or interpersonal conflicts &/or need to change behavior patterns, **and** Specific impairment(s) to be addressed can be delineated, **and** Intervention is to focus on the dynamics of members' problems, **and** Interventions are grounded in a specific & identifiable theoretical base which provides a framework for assessing change, **and** TX plan reflects need for the service. Continued stay: Service is necessary & appropriate to meet member's need as identified on TX plan. Progress notes document member's progress relative to goals identified in service plan but TX goals have not yet been achieved. Other: Service must be delivered by a therapist with at least a master's degree & who is licensed (or under supervision) by a recognized national/state accrediting body for psychology, psychiatry, counseling or social work at a level which allows provision of this service. Certified Addictions Counselors (CAC's) are credentialed to provide Individual/Family Therapy but only when addressing substance abuse TX issues &/or when their level of licensure specifically allows provision of this service. When this service is provided as part of a "low-end" service group a treatment strategy is sufficient to replace the MSP. This strategy describes what the clinician &/or member will do/achieve, at a minimum, prior to the next session or at some time in the future related to the focus of TX.
	Coordination of Care Criteria	Not specified.
	Authorization/Review Frequency	Tier 1 data submission for 60 units/yr. from start date of initial service. Unit = 15 minutes. Tier 1 data submission required for additional units after 1 yr. for provider previously utilizing benefit for same member if initial 60 units have not been exceeded within the yr. Tier 2 data submission required to exceed limit of 60 units/ yr. Maximum of 20 additional units authorized if specific number of units not requested.

Code	Service/Requirements	West Virginia
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service /activity to objective(s) in TX plan. Signature & credentials of person providing service, place, date of service, actual time spent providing service, start/stop time. TX strategies & objectives utilizing individual therapeutic interventions to be included in master TX plan & individual therapeutic intervention plan which expands on more generalized objective in master TX plan. Documentation on TX plan to include frequency at which service is to be provided. If provided as part of "low-end" service group, a TX strategy is sufficient to replace the MSP. Description of need for additional units for Tier 2 requests.
H0004HO HQ	**Behavioral Health Counseling, Professional, Group**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Member demonstrates intrapsychic or interpersonal conflicts &/or need to change behavior patterns, **and** Specific impairment(s) to be addressed can be delineated, **and** Intervention is to focus on the dynamics of members' problems, **and** Interventions are grounded in a specific & identifiable theoretical base which provides a framework for assessing change, **and** TX plan reflects the need for the service. Continued stay: Service is necessary & appropriate to meet member's need as identified on TX plan. Progress notes document member's progress relative to goals identified in TX plan but TX goals have not yet been achieved. Other: Service must be delivered by a therapist with at least a master's degree & who is licensed (or under supervision) by a recognized national/state accrediting body for psychology, psychiatry, counseling or social work at a level which allows provision of this service. CACs are credentialed to provide group therapy but only when addressing substance abuse TX issues &/or when their level of licensure specifically allows provision of this service. It is expected that service will be provided no less than twice/mo. or as indicated on TX plan as a part of an approved plan of phasing out this service (may be less than twice a month).Group size must be limited to maximum of 12 persons.
	Coordination of Care Criteria	Not specified.
	Authorization/Review Frequency	Tier 1 data submission required for 50 units/yr. from start date of initial service. Unit=15 minutes. Tier 1 data submission required after 1 yr. authorization period for provider previously using benefit for same member, if initial 50 units have not been exceeded within the yr. Tier 2 data submission required to exceed 50 unit limit/yr. Maximum of 20 additional units authorized if specific number of units not requested.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service/activity to objective(s) in the TX plan. Place & date of service, actual time spent providing the service, start/stop times. Signature & credentials of person providing

Code	Service/Requirements	West Virginia
		service.TX strategies & objectives utilized in therapeutic groups shall be included in master TX plan with frequency at which service is to be provided, & in a therapeutic group intervention plan which expands on the more generalized objective in master TX plan.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Registration for 60 units/yr. from start date of initial service. 60 units/yr. Unit = 15 minutes. Tier 2 data submission required for additional units after 1 yr. for provider previously utilizing benefit for same consumer. 60 units/ yr. Tier 2 data submission required to exceed the limit of 60 units/ yr. Maximum of 20 additional units authorized if specific number of units not requested.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service /activity to objective(s) in TX plan. Signature & credentials of person providing service, place of service, date of service, & actual time spent providing service, start/stop time. TX strategies & objectives utilizing individual therapeutic interventions in master TX plan & individual therapeutic intervention plan which expands on more generalized objective in master TX plan. Documentation on TX plan should also include frequency at which service is to be provided. If provided as part of "low-end" service group, a TX strategy is sufficient to replace the MSP. Description of need for additional units for Tier 2 requests.
H0004	**Behavioral Health Counseling, Supportive, Individual**	**Tier 2 Services**
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Need for assistance with day-to-day management & problem solving to help maintain progress toward identified goals **and** TX plan reflects need for service. Continued Stay: Service continues to be needed to maintain progress toward identified goals & assist with day-to-day management & problem-solving. Activity notes document progress relative to goals on TX plan, but TX goals have not been achieved. Other: More intensive TX not needed. Must be delivered by licensed professional or staff credentialed by agency, provided on scheduled basis by designated staff (except in cases of unscheduled crisis activities), & provided face-to-face. Service will be provided as needed, but may be as infrequent as once every 60 days.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 2 data submission for 20 units/yr. from start date of initial service. Unit = 15 minutes. Tier 2 data submission required for additional units after the 1 yr. authorization period by provider

Code	Service/Requirements	West Virginia
		previously using benefit for same member. 20 units/ yr. Tier 2 data submission required to exceed limit of 20 units/yr. Maximum of 20 additional units authorized if specific number of units not requested.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service/activity to an objective in TX plan. Documentation on TX plan to include frequency at which service is to be provided. Signature & credentials of person providing service, place & date of service, & actual time spent providing the service, start/stop time, & outcome of counseling intervention. Service may be provided due to an unscheduled crisis activity & when provided on an unscheduled basis activity note must include summary of events leading up to the crisis. Description of need for additional units for Tier 2 requests.
H0004 HQ	**Behavioral Health Counseling, Supportive, Group**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Need for assistance with day-to-day management & problem solving to help maintain progress toward identified goals **and** TX plan reflects need for service. Continued Stay: Activity notes document progress relative to goals on TX plan, but TX goals have not been achieved. Service continues to be needed to maintain progress toward identified goals & assist with day-to-day management & problem-solving. Other: Must be delivered by licensed professional or staff credentialed by agency, provided on scheduled basis by designated staff (except in cases of unscheduled crisis activities-not applicable to family groups), & provided face-to-face. Service will be provided as needed, but may be as infrequent as once every 60 days.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 2 data submission for 40 units/yr. from start date of initial service. Unit = 15 minutes. Tier 2 data submission required for additional units after the 1 yr. authorization period by provider previously using benefit for same member 40 units/ yr. Tier 2 data submission required to exceed limit of 40 units/yr. Maximum of 20 additional units authorized if specific number of units not requested.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service/activity to an objective in TX plan. Documentation on TX plan should include frequency at which service is to be provided. Signature & credentials of person providing service, place & date of service, & actual time spent providing the service, start/stop time, & outcome of counseling intervention. Description of need for additional units for Tier 2 requests.
H0032 AH	**Mental Health Service Plan**	

Code	Service/Requirements	West Virginia
PP	**Development by Non-Physician-Psychologist Participation**	
	Diagnostic Criteria	N/A
	Admission, Continued Stay, & Other Service Criteria	Admission: The activity of licensed psychologist, under the Rehabilitation Option, participating in TX plan meetings, reviews, & approval of TX plans. TX plans must be reviewed, signed & approved within 72 hrs. of TX plan meetings. Licensed psychologist must be physically present & participate in all TX team meetings for members who meet any of the following: a) receive psychotropic medication b) have a diagnosis of major psychosis or major affective disorder c) have major medical problems in addition to major psychosis or major medications d) presence of licensed psychologist has been specifically requested by case manager or member. Continued stay: Licensed psychologist will continue to participate in TX team process including 90 day updates. Other: Supervised psychologist may perform this service with oversight by the supervising licensed psychologist.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 2 data submission required for 4 units/30 days/. Unit = 15 minutes. Tier 2 data submission required for additional units after initial 30-day authorization by provider previously using benefit for same member. 4 units/30 days. Tier 2 data submission required to exceed limit of 4 units/30 days. Maximum of 1 additional unit authorized if specific number of units not requested.
	Documentation Requirements	For TX planning meetings & review & approval of TX plans, psychologist's signature on completed TX plan or 90 day update with date & duration of participation. Description of need for additional units for Tier 2 requests.
G9008 PP	**Physician Coordinated Care Oversight Services**	
	Diagnostic Criteria	N/A
	Admission, Continued Stay, & Other Service Criteria	Admission: The activity of the physician, under the Rehabilitation/Clinic Option, participating in TX plan meetings, reviews, & approval of TX plans. TX plans must be reviewed, signed & approved within 72 hrs. of TX plan meetings. Physician must be physically present & participate in all TX team meetings for members who meet any of the following: a) receive psychotropic medication b) have a DX of major psychosis or major affective disorder c) have major medical problems in addition to major psychosis or major medications d) presence of physician or licensed psychologist has been specifically requested by case manager or member. Continued stay:

Code	Service/Requirements	West Virginia
		Physician will continue to participate in TX team process including 90 day updates. Other: Physician assistant and nurse practitioner with psychiatric specialty may perform this service. Nurse practitioner without psychiatric specialty may perform this service under the supervision of a psychiatrist.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 2 data submission required for 4 units/30 days. Unit = 15 minutes. Tier 2 data submission required for additional units after initial 30-day authorization for provider previously utilizing benefit for same member. 4 units/30 days. Tier 2 data submission required to exceed limit of 4 units/ 30 days. Maximum of 1 additional unit authorized if specific number of units not requested.
	Documentation Requirements	For TX planning meetings & review & approval of TX plans, physician's signature on completed TX plan or 90 day update with date & duration of participation. Description of need for additional units for Tier 2 requests.
90887	**Case Consultation**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Consultant's specialized expertise needed for development & monitoring TX interventions &/or outcomes, **or** Consultant needed to review member's progress & make recommendations **or** Discussion of progress of member regarding outcomes, functional limitation, compliance with TX &/or symptomatology is necessary & consulting professional's area of expertise is required. Continued stay: None Other: May not be used during TX planning. Professional staff that participated in member's TX plan within the current 90- day period or who were directed to provide TX cannot bill for case consultation. Consultant cannot be member's case manager. Excludes training & staff supervision, caseload review & medication review. Consultant must be licensed or certified in area of expertise & enrolled Medicaid provider or employee of contracted agency.
	Coordination of Care Requirements	Assistance in development/continuation of appropriate services based on recommendations.
	Authorization/Review Frequency	Event/92days. Unit = Event. Tier 2 data submission required for 1 event/92 days.
	Documentation Requirements	Summary of consultation including, purpose, results & procedures interpreted or explained, activities/services discussed, recommendation with desired outcomes, date, location, & duration of contact. Only the consulting professional's time may be billed. Other professional(s) involved in the consultation may not bill case consultation.
T1017	**Targeted Case Management**	

Code	Service/Requirements	West Virginia
	Service	
	Diagnostic Requirements	For adults 18 or older who have a behavioral health DX. Eligible diagnostic categories are substance-related disorders, schizophrenia, other psychotic disorders, mood disorders, delusional disorders, & borderline personality disorder or a developmental disability (not enrolled in MR/DD Waiver program) as defined by WV code.
	Admission, Continued Stay, & Other Service Criteria	Admission; Qualifying DX **and** Functional impairments in 2 or more areas that are substantial & measurable (for MR/DD must demonstrate functional limitations in 3 major life areas) Continued stay: Member continues to meet admission criteria Member continues to choose TCM. Other: Member cannot be receiving case management services under HCBS. Cannot receive TCM while in ICF/MR, inpatient psychiatric/nursing facility except 30 days prior to discharge as part of discharge planning. Member does not require Level II or III services. Some exceptions to psychiatric/psychological authorization (e.g., persons previously institutionalized, victims of abuse, neglect) Staff Qualifications: psychologist with master's or doctoral degree from an accredited program, licensed social worker, RN, master's or bachelor's degree in human services field previous certification on basis of training & experience by Office of Behavioral Health Services. Includes descriptions of components of TCM: assessment, service planning, linkage/referral, advocacy, crisis response planning, & service plan evaluation.
	Coordination of Care Requirements	Linkage/referral, advocacy, assistance in accessing crisis services, coordination of assessments, service planning.
	Authorization/Review Frequency	Tier 2 only service(s) or TCM only: 36 units/ 92 days. Unit = 15 minutes. Tier 2 data required for additional units after 92 days from initial date of service by provider previously using benefit for same member. 36 units/92 days. Tier 3 required to exceed limit of 36 units/92 days.
	Documentation Requirements	A BMS approved agency for provision of TCM for Medicaid reimbursement must maintain the following: 1. Evidence in each clinical record that recipient is in a targeted population & having an accompanying assessment of functional abilities (as determined by an appropriate, standardized instrument) & as determined by a psychiatrist or licensed clinical psychologist. 2. Each recipient will have an individualized service plan, updated at 90 day intervals or more frequently as indicated by member need. 3. Each member's record shall include a functional assessment indicating a need for case management. 4. Each clinical record must include documentation specific to services/activities reimbursed as Medicaid TCM with specific notes for each individual case management service/activity

Code	Service/Requirements	West Virginia
		provided & billed, dated & signed by case manager. Purpose & content of the activity, outcome achieved & • Description of type of contact provided (e.g., face-to-face, correspondence, telephone) • Description of type of activity provided (i.e., assessment, service planning, linkage/referral, advocacy, crisis response planning, service plan/evaluation) & • Place where activity occurred & actual time spent providing each activity • Service goal/objective in individual's plan of service which activity addresses • Start/stop time for each activity. 5. Unit of service is 15 minutes. Claims are not processed for less than a full unit of service. In filing claims for Medicaid reimbursement, amount of time documented in minutes must be totaled & divided by 15. 6. Documentation must demonstrate that only 1 case manager's time is billed for any specific unit of service provided.
T1017 CM	**Targeted Case Management Service**	**Tier 3 Services**
	Diagnostic Criteria	For adults 18 or older who have a behavioral health DX. Eligible diagnostic categories are substance-related disorders, schizophrenia, other psychotic disorders, mood disorders, delusional disorders, & borderline personality disorder or a developmental disability (not enrolled in MR/DD Waiver program) as defined by WV code..
	Admission, Continued Stay, & Other Service Criteria	Admission: Qualifying DX **and** Functional impairments in 2 or more areas that are substantial & measurable (for MR/DD must demonstrate functional limitations in 3 major life areas) Continued stay: Member continues to meet admission criteria Member continues to choose TCM. Other: Member cannot be receiving case management services under HCBS. Cannot receive TCM while in ICF/MR, inpatient psychiatric/nursing facility except 30 days prior to discharge as part of discharge planning. Member does not require Level II or III services. Some exceptions to psychiatric/psychological authorization (e.g., persons previously institutionalized, victims of abuse, neglect) Staff Qualifications: psychologist with master's or doctoral degree from an accredited program, licensed social worker, RN, master's or bachelor's degree in human services field (e.g., counseling, special education, psychology, rehabilitation counseling, nursing), previous certification on basis of training & experience by Office of Behavioral Health Services. Includes descriptions of components of TCM: assessment, service planning, linkage/referral, advocacy, crisis response planning, & service plan evaluation.
	Coordination of Care	Linkage/referral, advocacy, assistance in accessing crisis

Code	Service/Requirements	West Virginia
	Requirements	services, coordination of assessments, service planning.
	Authorization/Review Frequency	Tier 3 only service(s) or Intensive TCM only: 96 units/92 days Unit = 15 minutes. Tier 3 or Tier 2 and 3 service combination **or** request to exceed 36 units at Tier 2 (requires Tier 3 data submission): 96 units/per 92 days. Reauthorization: Tier 3 only service or Intensive TCM only: 96 units/92 days. Tier 3 or Tier 2 and 3 service combination **or** request to exceed 36 units at Tier 2 (requires Tier 3 data submission): 96 units/ 92 days.
	Documentation Requirements	A BMS approved agency for provision of TCM for Medicaid reimbursement must maintain the following: 1. Evidence in each clinical record that each recipient is in a targeted population & having an accompanying assessment of functional abilities (as determined by an appropriate, standardized instrument) & as determined by a psychiatrist or licensed clinical psychologist. 2. Each member will have an individualized service plan, updated at 90 day intervals or more frequently as indicated by member need. 3. Each member's record shall include a functional assessment indicating a need for case management. 4. Each clinical record must include documentation specific to services/activities reimbursed as Medicaid TCM with specific notes for each individual case management service/activity provided & billed, dated & signed by case manager. Purpose & content of the activity, outcome achieved & • Description of type of contact provide (e.g., face-to-face, correspondence, telephone contacts) • Description of type of activity provided (i.e., assessment, service planning, linkage/referral, advocacy, crisis response planning, service plan/evaluation) & • Place where the activity occurred & actual time spent providing each activity • The service goal/objective in individual's plan of service which the activity addresses • Start /stop time for each activity. 5. Unit of service is 15 minutes. Claims are not processed for less than a full unit of service. In filing claims for Medicaid reimbursement, the amount of time documented in minutes must be totaled & divided by 15. 6. Documentation must demonstrate that only 1 case manager's time is billed for any specific unit of service provided. Required Tier 3 data includes functional assessment
H2015	**Comprehensive Community Support Services**	
	Diagnostic Criteria	SPMI
	Admission, Continued Stay, & Other Service Criteria	Admission: SPMI **and** Symptomatology or functional impairment is mild to moderate, **and** Level of structure needed for activities of daily living that cannot

Code	Service/Requirements	West Virginia
		be met in community with natural supports or, member does not have a means for acquisition or maintenance of skills through natural support system or community resources, **and** Does not require more intensive Day TX services, **and** Individualized TX plan delineates goals that are flexible, relevant to member's identified needs & futures planning, tailored to the individual, & attempt to utilize community resources & natural supports. <u>Continued stay:</u> Progress is documented relative to program objectives & futures planning, **and** Efforts to link to natural supports/activities/services in community are documented, **and** New areas of need are identified on TX plan to be addressed in the program as needed. <u>Other:</u> Examples of categories of skill areas: Health education, meal preparation, personal hygiene, utilization of community resources, interpersonal skills, problem solving, communications, stress reduction, interpersonal relationships, interactions with strangers, social skill development & coping skills, social competence, understanding mental illness. May be long-term service with activities provided on or off site. Service may not exceed 4 hrs/day, 5 days/wk. Staff to client ratio is maximum 1:8 for H2015 U2 or a maximum of 1:12 for H2015 U1. Services must be age & functionally appropriate & delivered at level that best meets needs of the individual participant. Supervisor requirement: QMHP with minimum of BA degree & experience working with individuals with SPMI. FTE equivalent of supervisor must reflect actual number of hrs. spent on site & supervisor responsibility as part of direct care ratios (if any). Paraprofessional staff: at least 18 years old; H.S. diploma or G.E.D.; experience & skills in working with individuals with SPMI. Professionals or paraprofessionals who are otherwise qualified may provide Community Focused TX as a 'peer'. Community Focused TX Program Certification: all programs must be certified by BMS. Any changes from an approved original certification must be submitted & approved.
	Coordination of Care Requirements	Not specified.
	Authorization/Review Frequency	Tier 3 data submission for 1056 units/ 92 days. Unit= 15 minutes.
	Documentation Requirements	**Daily Notes:** Documentation for each daily episode of services including date of attendance, description of type of service/activity provided, relationship of service/activity to objectives in TX plan & relative progress. Place & date of service, start/stop time, & participation level of consumer in each specified activity. **90 Day Review:** Services must be reviewed at 90 day intervals & TX/Service Plan goals & objectives relevant to services must be adjusted to recipient's changing needs. No requirement for separate TX/service plan for these services. **Daily Attendance Roster:** reflecting participants in service,

Code	Service/Requirements	West Virginia
		signed & dated by participating staff, reflect adequate staff/member ratios, start/stop times
H2012	**Day Treatment**	
	Diagnostic Criteria	SPMI or substance abuse DX
	Admission, Continued Stay, & Other Service Criteria	Admission: SPMI or substance abuse DX **and** Symptomatology or functional impairment indicates need for intensive services, **and** Need for level of structure for activities of daily living that cannot be met at a lower level, **and** Member has previously demonstrated capability of mastering more complex personal & interpersonal life skills (e.g., problem solving, assertiveness, self-advocacy, shopping, meal preparation, development of leisure skills, & use of community resources) Reasonable expectation that consumer can improve demonstrably within 3 mos. **and** Individualized TX plan delineates specific day TX goals which are flexible, tailored to the individual, & attempt to utilize community & natural supports. <u>Continued stay:</u> Progress is clearly evident & notes document progress relative to day TX objectives identified in master TX plan. Continuation of remaining objectives to achieve goal are appropriate. New areas of need are identified on TX plan to be addressed in the day TX program. <u>Other:</u> Skill development areas: daily living skills, interpersonal skills, leisure & social skill development, prevocational skills, & disability coping skills. Day TX not considered a long-term maintenance program but an active TX program with progression and outcomes. Services must be available for 5 days/wk. a minimum of 4 hrs/day. Activities provided for the purpose of leisure, or recreation, are not billable services. Any objective that results in no progress (or desired change) after 2 consecutive 90-day intervals must be discontinued or modified. Services must be age and functionally appropriate & delivered at a level that best meets the needs of the individual participant. Recommended ratio for mental health & substance abuse members is 1:5, although the Rehabilitation Manual allows up to 1:7. Supervisor requirement: BA Degree with 1 yr. supervised experience. 15 hrs. every 2 yrs. of continued education relevant to targeted population served. Paraprofessional staff: at least 18 yrs. old; H.S. diploma or G.E.D; Certified in Red Cross CPR & First Aid; & successfully complete behavioral health agency training or equivalent. Documentation of training & qualification must be maintained by provider agency. Day TX Program Certification required every 2 yrs.
	Coordination of Care Requirements	Not specified.

Code	Service/Requirements	West Virginia
	Authorization/Review Frequency	Tier 3 data submission for 396 units/92days. Unit=60 minutes
	Documentation Requirements	**Daily Notes**: Documentation for each daily episode of day TX including total time in attendance at the program, describing type of service/activity provided, & relationship of the service/activity to objectives in TX plan. Place & date of service, actual time spent providing the service, staff/member ratio, & participation of member in each daily activity. This documentation is not required to be stored in the main clinical record but must be maintained & available for review. **Monthly Summary**: Summarizes progress on objectives specified in member's TX or day TX plan. Must be placed in member's master clinical record. **Daily Attendance Roster**: reflecting participants in the service signed & dated by participating staff.
H2012 MR	**Day Treatment**	
	Diagnostic Criteria	Axis I Severe DD DX or Axis II MR/DD DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Axis I Severe DD DX or Axis II MR/DD DX & need for intensive services, **and** Clinical & behavioral issues that are unmanageable in traditional OP TX & require intensive, coordinated, multidisciplinary intervention in therapeutic milieu, **and** Level of functioning precludes service provision in a less restrictive LOC & substantial deficits in daily living & 1 or more of: social skills, vocational/academic skills, community/family reintegration, **and** Expectation for progress related to specific day TX goals within 3 months, **and** Day TX goals are specific, flexible, & tailored to the individual with attempts to use community & natural supports whenever possible to augment TX. Continued stay: Progress clearly evident, notes document progress relative to day TX objectives in MSP. Continuation of remaining objectives to achieve goal are appropriate. New areas of need identified on TX plan to be addressed in day TX program. Other: Areas of intervention include but not limited to: self-care, emergency, mobility, nutritional, social, & functional community skills; communication & speech instruction, carryover of physical &/or occupational therapy objectives, interpersonal skills instruction, volunteering in community settings, citizenship rights & responsibilities, self-advocacy, other services needed for individual to participate in community setting of his/her choice. Day TX not considered a long-term maintenance program, but active TX program with progression & outcomes. Activities for purpose of leisure or recreation not billable. Any objective that results in no progress or desired change after 2 consecutive 90 day intervals must be discontinued or modified. Supervisor requirement: BA with 1 yr. supervised experience. 15 hrs. continuing education every 2 yrs. relevant to population.

Code	Service/Requirements	West Virginia
		Paraprofessional staff: at least 18 yrs. Old, HS diploma or GED, Red Cross CPR & first aid certification, Agency training or equivalent. Maximum staff participant ratio: 1:5 Day TX program certification every 2 yrs.
	Coordination of Care Requirements	Intensive, coordinated, multidisciplinary intervention.
	Authorization/Review Frequency	Tier 3 data submission for 396 units/92 days. Unit=60 minutes
	Documentation Requirements	**Daily notes:** for each daily TX episode, total time in attendance, type of service/activity provided, relationship of service/activity to TX plan objectives. Place & date of service, actual time spent providing service, staff/consumer ratio, consumer participation in each activity. **Monthly Summary**: summarizing progress on TX plan objectives. **Daily Attendance Roster:** reflecting participants in service, signed & dated by participating staff.
H0040	**Assertive Community Treatment (ACT)**	
	Diagnostic Criteria	Severe & persistent mental health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: SPMI **and** An array of services is required for member to remain in a community based setting & prevent further hospitalization, **and** Previous mental health TX services &/or is currently receiving services, **and** 3 or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months, **or** 5 or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or crisis stabilization program in the past 24 months, **or** 180 days total length of stay in a psychiatric unit or psychiatric hospital within the past 12 months. Continued Stay: Member continues to require an array of services to preserve community placement, **and** Progress/stability is documented & efforts to link to natural supports/activities/services in the community are documented, **&/or** Symptoms, functional impairments & new areas of need are identified on the TX plan to be addressed in the program as needed. Other: Homeless persons with SPMI, individuals with a SPMI who have frequent contact with law enforcement or criminal justice system (a single serious offense may be evaluated on a case by case basis) & individuals with co-occurring mental illness & chemical addiction who require frequent monitoring are not eligible for ACT. May be long-term service with activities provided on or off site (at least 75% of services must be delivered outside the program offices). Certified ACT Team must always include required minimum

Code	Service/Requirements	West Virginia
		staffing. Maximum of staff/client ratio is 1:10, (ratio may not include the psychiatrist, Physician's Assistant, Nurse Practitioner or Clinical Nurse Specialist in the calculation). Non-ACT clients cannot be served by the ACT Team. Maximum number of persons that may be served by a Qualified Team in urban areas is 120 & in rural areas 80. Direct services that must be provided by the ACT team are: a. Assertive Outreach b. Sustained effort to engage the member c. Assessment d. Recovery oriented individual TX planning & oversight e. Linkage with a continuum of mental health services, maintaining ongoing involvement with the individual during stays in environments such as inpatient care, convalescent care facilities, community care hospitals or rehabilitation centers f. Member-specific advocacy g. Assistance with securing basic necessities (e.g. food, income, housing, medical & dental care, other social, educational, vocational & recreational services) h. Ongoing services to ensure maintenance of living arrangements during periods of institutional care, such as paying rent & utilities. The member & his/her support system remain responsible for these expenses. The ACT Team ensures these needs are addressed. i. Counseling, problem solving & personal support j. Psychiatric services k. Medication management l. Activities of daily living/ community living skills teaching, behavior management &/or direct assistance m. 24- hour capability, 7 days a week, for crisis response for ACT clients n. Providing or assisting with transportation o. Representative payeeship when needed p. Collaboration with family/ personal support network q. Information on advanced psychiatric directives 4. The ACT Team is a multi-disciplinary, multifunctional mix which includes: a psychiatrist (at least 16 hours a week) **NOTE: Certified Physicians Assistants, Nurse Practitioners with Psychiatric Certification or Clinical Nurse Specialists with psychiatric experience or certification may substitute for the Psychiatrist if they are under direct clinical supervision of a psychiatrist & the psychiatrist evidences direct clinical involvement with the ACT Team & clients**; & a minimum of 5 full-time equivalent staff who must collectively meet these requirements: 1) a full-time (40 hrs./ week) staff team leader/supervisor who is a QMHP with 3 yrs. experience working with the seriously mentally ill and 2 yrs. supervisory experience & who has a minimum of a Master's degree in Counseling, Social Work or Psychology & has a Master's level license (or is actively pursuing a Master's level license); 2) a FTE RN with a minimum of 2 yrs. psychiatric experience; 3) a Substance Abuse Specialist with a Master's Degree in Counseling, Social Work or Psychology serves as either a core team member (1 of the 5 FTE staff) or as an additional team member (in addition to the

Code	Service/Requirements	West Virginia
		required 5 FTE staff) &; 4) 2 FTE team members who serve only ACT members. As long as the requirement for a fulltime team leader is met, all other requirements may be met with multiple staff persons as long as the FTE requirement & required expertise is present on the ACT team. 5. Psychiatrist (or other staff specified to meet qualifications for this team member) must be involved with clients & team a minimum of 16 hrs./week. Activity includes participation in daily ACT Team meeting (may be by tele-video conference) with at least 1 face-to-face meeting with the team weekly. Psychiatrist must at minimum be physically present at member's annual service/TX planning session. 6. ACT Team must meet daily to review all cases. Each active member must be reviewed intensively at least once weekly & documentation of this review placed in member's record. Less intensive daily reviews do not require documentation in specific member record but may be documented on daily team meeting log. Psychiatrist or representative & team members may participate through tele-video conferencing, but entire team must meet face-to-face once weekly.
	Coordination of Care Requirements	Linkage to mental health services, community based resources, natural supports, activities. Ongoing involvement when member is hospitalized.
	Authorization/Review Frequency	Tier 3 data submission for 365 units/365 days. Unit=1 calendar day.
	Documentation Requirements	A confidential individual TX record must be maintained including documentation related to nature & extent of services provided, such that a person unfamiliar with the ACT team can identify member's TX needs & services rendered. Copy of the ACT authorization. ACT Admission Status Report detailing specific eligibility criteria met for inclusion into the service along with functional impairments & symptom acuity to be addressed through ACT. An individualized ACT Service Plan (ACTion Plan) must identify Qualified Team Members providing ACT. This plan is a fluid document with a continuous review cycle, based upon information identified in the ACT Admission Status Report. It must reflect member's consent for ACT services & identify goals, objectives & specific services to be provided under ACT. ACTion Plan must be developed within 30 days of ACT authorization. 90 day review summarizing member's level of progress & purpose, content & outcome of specific services provided to meet TX goals. Summary documentation of daily team meetings should be kept & relevant issues, follow-up, & responsible parties noted. Specific services provided to member must be documented in individual service record & should include service provided & a summary of activity including the relationship of service/activity to TX plan &/or a specific need identified in daily team review. Must include signature, title & credentials of ACT Team Member providing the service, place & date of service. A Discharge Status Summary is required to report status of the member at discharge, identify specific discharge criteria met,

Code	Service/Requirements	West Virginia
		circumstances & reasons for discharge, length of receiving ACT service, responses to ACT services.
H2024 U4 **H2014 U1** **H2014 HN U4** **H2014 HN U1**	**Skills Training & Development (1:1 by Paraprofessional** **Skills Training & Development (1:4 by Paraprofessional** **Skills Training & Development (1:1 by Professional)** **Skills Training & Development (1:4 by Professional**	
	Diagnostic Criteria	Known persistent mental health or substance abuse DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Known persistent mental health or substance abuse DX & requires intensive services **and** Measurable, identified skills deficits related to the MH/SA DX & reflects skills that member once held & then lost due to neglect, abuse, institutionalization, etc., **and** Reasonable expectations that member can demonstrate improvement in 3 months, **and** Member, by history, has required periodic hospitalizations & exhibits symptoms or functional impairments that are severe enough to require hospitalization, **or** Member has a mood or thought disorder which interferes with ability to resume work, family, or school responsibilities unless psychiatric/social/rehabilitative services are provided & Skills Training & Development is the appropriate intervention to remediate skill deficits related to symptoms of the illness, **or** Member has stabilized during acute hospital or partial hospitalization care but would benefit from transitional services to reestablish their role in the community, **or** Member does not have adequate family support & therefore is in need of assistance to improve or preserve ADL's to remain stable & prevent likely admission to an inpatient setting if targeted skills are not remediated, or to transition to independent living from a more restrictive setting when this is the specific discharge plan. Continued stay: Progress is evident & noted in documentation related to goals & objectives identified on individual TX plan with date to discontinue. If progress indicates that Skills Training & Development objectives are used to preserve functioning & the condition is stable, there must be documentation of need to continue the objective. TX plan review documentation reflects history of symptoms & functional impairments that indicate a need for continued Skills Training & Development Service. Other: Therapeutic activities include, but are not limited to, learning & demonstrating personal hygiene skills, parenting skills, managing living space, manners, sexuality, social appropriateness & teaching daily living skills. Services may be provided to an individual in his/her natural environment through a structured program.

Code	Service/Requirements	West Virginia
		Only support services, essential to maintain the member in the community are allowable under this code. These include: medical appointments, pharmacy, grocery shopping, other essential appointments to maintain entitlements (i.e., Social Security Office, DHHR). Alternative resources that were explored must be documented and continued alternatives must be sought within the 90-day service period. If services are provided in a group, it must be limited to 4 members/staff member. In any setting, this service targets members who require direct prompting or direct intervention by a provider. Recreational trips, visits to the mall, recreational/leisure time activities, & social events are not essential support services & cannot be billed under this code. Skills Training and Development is a rehabilitation service only & must be medically necessary. Member must meet diagnostic eligibility, meet criteria for Level III service, & specifically require Skills Training & Development. Member's plan must be individualized, age & developmentally appropriate, & relate to the specific criteria applicable to that member. Day TX Services cannot be provided during hrs. when Skills Training & Development is provided.
	Coordination of Care Requirements	Not specified.
	Authorization/Review Frequency	Tier 3 data submission for 600 units/92 days. Unit=15 minutes
	Documentation Requirements	Activity note describing the type of service/activity provided, & relationship of the service/activity to objectives in TX plan. Place & date of service, actual time spent providing the service with total number of billable units identified on each page of documentation. Attendance Roster: must reflect a listing of all participants & be signed & dated by participating staff.
H2019 HO	**Therapeutic Behavioral Services-Development**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Moderate to severe symptoms &/or functional impairments & specific behaviors which interfere with age appropriate adaptive & psychological functioning, **and** Specific targeted behaviors can be identified & interventions to modify these behaviors can be developed, **and** Progress can be quantified & documented, **and** Problematic or high risk behaviors that impact social problem solving & ability to form or sustain a relationship with family or other significant persons, **or** Behaviors are such that structured behavioral management is indicated to assist the member to remain in the community, school, living setting, or maintain other ADLs. Continued stay: Data analysis & review indicates continuation or modification of therapeutic behavioral services plan.

Code	Service/Requirements	West Virginia
		Other: Staff qualifications: Behavior Management Specialist: (Master's level with graduate training in applied behavioral analysis), responsible for all aspects of behavior management services provided by assistants, must review & co-sign all documentation. Behavior Management Assistant: Bachelor's in human services field, & agency certification.
	Coordination of Care Requirements	Not specified.
	Authorization/Review Frequency	Tier 3 data submission for 120 units/per 92 days. Unit=15 minutes
	Documentation Requirements	The clinical record contains activity notes that identify the specific component of Therapeutic Behavioral Health services (i.e., Behavior Assessment, Plan Development, Implementation Training, Therapeutic Behavioral Services Implementation, Data Analysis & Review) that was performed, amount of time spent, date, start/stop times & signature, & credentials of staff member who performed the service. **Behavior Assessment documentation** must be present prior to development of the behavior management plan. Documentation must reflect in the following order: 1. Identification of target behavior(s). 2. Specific description of each target behavior in terms capable of objective, quantified measurement. 3. Collection of baseline data on each target behavior to obtain an objective, quantifiable determination of its occurrence/nonoccurrence. 4. Review & analysis of baseline data to determine objectively, if a need for further Therapeutic Behavioral Services exists. Following implementation of the therapeutic behavioral services plan, behavior management assessment must include place of service, actual time spent providing the service, start/stop times, & rationale for such assessment, which may take 1 of 2 forms: 1. Identification of a new target behavior. Should this occur, behavior assessment must meet requirements outlined in steps 1-4 above to provide objective documentation of the need to modify the plan. 2. Objective determination through data analysis & review that the plan is not effective. If this occurs, behavior assessment should be conducted to determine if the plan is being implemented correctly. If not, implementation training must reoccur. If the plan is being implemented correctly further data based assessment to determine whether to modify the plan will occur. Documentation of the latter must reflect specific components of the plan addressed & modified to obtain the desired behavior (e.g., methods of behavioral intervention, schedules & methods of reinforcements, etc.). **Plan Development** must include specific components of the plan itself that were developed, place & date of service, actual time spent providing service, start/stop times. **Implementation Training** must document training of implementation staff as defined by the plan, definitions of the behavior(s) targeted for change, & specific steps necessary for plan implementation. Place & date of service, actual time spent

Code	Service/Requirements	West Virginia
		proving service, start/stop times. **Therapeutic Behavioral Services-Implementation** must be documented as specified in the documentation section for procedure code H2019 HO. **A therapeutic behavioral services plan for which there is no documentation of therapeutic behavioral services implementation activity is invalid for billing purposes except for those activities related to assessment where decision made based on assessment data that it was not appropriate to proceed.** **Data Analysis & Review:** must document a measured amount of each target behavior, comparison of that amount to a previously documented amount &, based on that measured amount, a determination of continuation, modification, or termination of the plan. Place & date of service, actual time spent proving service, start/stop times. **Therapeutic Behavioral Services Plan** Must include at a minimum, the following components in their listed order & must label those components as such: A separate, freestanding document labeled **Behavior Management Plan.** **Name & Member Identification Number** of the member for whom the plan has been developed. **Implementation Date** **Target Behaviors/Specific Descriptions:** Behaviors identified for change & their respective descriptions which must be capable of being quantified measurement. **Baseline Data:** Quantified measurement of each target behavior prior to intervention & dates when this data collection began & ended. **Criteria for Success:** Quantified amount of behavior change for each target behavior that must occur within a specified period of time for the plan to be successfully terminated. **Methods of Behavioral Intervention** includes the following: **Method:** Description of the behavioral intervention that implementation staff will employ given the occurrence/nonoccurrence of target behavior(s). **Method & Schedule of Reinforcement:** Description of the positive consequence that will be provided when member does what is expected & when it is to be provided. **Data Collection:** Description of the quantified information that include who collects the information & what type of quantified information is recorded, such as frequency of duration of behavior. Information must be the same type as that collected during baseline so that comparison can occur. **Responsible Persons** **Signatures & credentials, licensure**. **Behavior Protocol Documentation** Summary of objective, quantified baseline data, rationale for the development of the protocol, & recommendations for consistent response(s) upon the occurrence/nonoccurrence of target behavior(s), date the protocol was developed, time spent providing service, start/stop times.\, signature& credentials of person preparing protocol. **Therapeutic Behavioral Services Maintenance Plan Documentation**

Code	Service/Requirements	West Virginia
		Summary of objective, quantified implementation data (collected during implementation of the plan), rationale for development of a maintenance plan (i.e., criteria for success has been achieved), & recommendation for consistent response(s) upon the occurrence/nonoccurrence of target behavior(s), date the maintenance plan was developed, time spent providing service, start/stop times.\, signature& credentials of person preparing protocol.
H2019	**Therapeutic Behavioral Services-Implementation**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Maladaptive behaviors that are resistant to verbally oriented TXs (individual, group, or day services), **and** Admission criteria for Therapeutic Behavioral Services-Development have been met, **and** There is a valid Therapeutic Behavioral Services Plan to be implemented. Continued stay: Target problem behaviors, which are addressed in the Therapeutic Behavioral Services Plan, persist at the level documented, **and/or** New problem behaviors have appeared which have been incorporated into the Therapeutic Behavioral Services Plan & resubmitted for authorization, **or** Relevant progress towards management of the targeted behavior has been observed & documented but behavioral goals have not been reached. Other: General observation, data collection &/or monitoring are not billable implementation activities. Activity provided for purpose of leisure or recreation is not billable.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 3 data submission for 600 units/92 days. Unit=15 minutes. Service must be requested with (H2019 HO) Therapeutic Behavioral Services- Development.
	Documentation Requirements	Documentation must occur as services are being provided or within a daily period, & include: place & date of service, start/stop times, individualized intervention used, methods, measurements, outcome of implementation, delivery of service, signature of implementing staff.
H0004 HO IS	**Behavioral Health Counseling, Professional, Individual**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Member demonstrates intrapsychic or interpersonal conflicts &/or need to change behavior patterns, **and** Specific impairment(s) to be addressed can be delineated, **and** Intervention is to focus on the dynamics of members' problems, **and** Interventions are grounded in a specific & identifiable theoretical

Code	Service/Requirements	West Virginia
		base which provides a framework for assessing change, **and** TX plan reflects the need for the service. <u>Continued stay:</u> Service is necessary & appropriate to meet member's need as identified on TX plan. Progress notes document member's progress relative to goals identified in the service plan but TX goals have not yet been achieved. <u>Other:</u> Service must be delivered by a therapist with at least a master's degree & who is licensed (or under supervision) by a recognized national/state accrediting body for psychology, psychiatry, counseling or social work at a level which allows provision of this service. CAC's are credentialed to provide Individual/Family Therapy but only when addressing substance abuse TX issues &/or when their level of licensure specifically allows provision of this service. Provider must have an approved intensive program per the IRG/APS protocol.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Tier 3 data submission required. Units determined by individual intensive service description approved by IRG/APS. Unit = 15 minutes Tier 3 data submission required for additional units during or after initial authorization period by provider previously utilizing benefit for same member.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service/activity to objective(s) in TX plan. Place & date of service, actual time spent providing the service, start/stop times. TX strategies & objectives using individual therapeutic interventions shall be included in master TX plan & in an individual therapeutic intervention plan which expands on the more generalized objective in master TX plan.
H0004 HO HQ IS	**Behavioral Health Counseling, Professional, Group**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Behavioral health DX **and** Member demonstrates intrapsychic or interpersonal conflicts &/or need to change behavior patterns, **and** Specific impairment(s) to be addressed can be delineated, **and** Intervention is to focus on the dynamics of member's problems, **and** Interventions are grounded in a specific & identifiable theoretical base which provides a framework for assessing change, **and** TX plan reflects the need for the service. <u>Continued stay:</u> Service is necessary & appropriate to meet member's need as identified on TX plan. Progress notes document member's progress relative to goals identified in TX plan but TX goals have not yet been achieved. <u>Other:</u> Service must be delivered by a therapist with at least a master's

Code	Service/Requirements	West Virginia
		degree & who is licensed (or under supervision) by a recognized national/state accrediting body for psychology, psychiatry, counseling or social work at a level which allows provision of this service. CACs are credentialed to provide group therapy but only when addressing substance abuse TX issues &/or when their level of licensure specifically allows provision of this service. It is expected that service will be provided no less than twice/mo. or as indicated on TX plan as a part of an approved plan of phasing out this service (may be less than twice a month). Group size must be limited to maximum of 12 persons. Provider must have an approved intensive description per the IRG/APS protocol.
	Coordination of Care Requirements	Not specified.
	Authorization/Review Frequency	Tier 3 data submission required. Units determined by individual intensive service description approved by IRG/APS. Unit = 15 minutes. Tier 3 data submission required for additional units during or after initial authorization period by provider previously utilizing benefit for same member.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service/activity to an objective(s) in the TX plan. Place & date of service, actual time spent providing the service, start/stop times. TX strategies & objectives utilized in therapeutic groups shall be included in master TX plan & in a therapeutic group intervention plan which expands on the more generalized objective in master TX plan.
H0004 IS	**Behavioral Health Counseling, Supportive, Individual**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	<u>Admission:</u> Behavioral health DX **and** Need for assistance with day-to- day management & problem solving to help maintain progress toward identified goals, **and** TX plan reflects need for the service. <u>Continued stay:</u> Service continues to be needed to maintain progress towards identified goals & assist in day-to-day management & problem solving. Activity notes document progress relative to the objective on TX plan but TX goals have not yet been achieved. <u>Other:</u> Must be delivered by licensed professional or staff credentialed by the agency. Must be provided on a scheduled basis by designated staff (except in cases of unscheduled crisis activities). Must be provided face-to-face. It is expected that this service will be provided as needed, but may be as infrequent as once/60 days. Provider must have an approved intensive service description per the IRG/APS protocol.
	Coordination of Care Requirements	Not specified.

Code	Service/Requirements	West Virginia
	Authorization/Review Frequency	Tier 3 data submission required. Units determined by individual intensive service description approved by IRG/APS. Unit = 15 minutes. Tier 3 data submission required for additional units during or after initial authorization period by provider previously utilizing benefit for same member.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service/activity to objective(s) in TX plan. Place & date of service, actual time spent providing the service, start/stop times, outcome of counseling intervention.
H0004 HQ IS	**Behavioral Health Counseling, Supportive, Group**	
	Diagnostic Criteria	Behavioral health DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Behavioral health DX **and** Need for assistance day-to- day management & problem solving to help maintain progress toward identified goals, **and** TX plan reflects need for the service. Continued stay: Activity notes document progress relative to the objective on TX plan but TX goals have not yet been achieved. Service continues to be needed to maintain progress towards identified goals & assist in day-to-day management & problem solving. Other: Must be delivered by licensed professional or staff credentialed by the agency. Must be provided on a scheduled basis by designated staff (except in cases of unscheduled crisis activities-not applicable to family groups). Must be provided face-to-face. It is expected that this service will be provided as needed, but may be as infrequent as once/60 days. Provider must have an approved intensive service description program per the IRG/APS protocol.
	Coordination of Care Requirements	Not specified.
	Authorization/Review Frequency	Tier 3 data submission required. Units determined by individual intensive service description approved by IRG/APS. Unit = 15 minutes Tier 3 data submission required for additional units during or after initial authorization period by provider previously utilizing benefit for same member.
	Documentation Requirements	Activity note describing type of service/activity provided & relationship of service/activity to objective(s) in TX plan. Place & date of service, actual time spent providing the service, start/stop times, outcome of counseling intervention.
H0036	**Community Psychiatric Supportive Treatment**	**Tier 4 High Intensity Services**
	Diagnostic Criteria	Acute psychiatric signs & symptoms
	Admission, Continued Stay, & Other Service Criteria	Admission: Psychiatric Signs & Symptoms: Member is experiencing a crisis due to a mental condition &/or impairment in functioning due to acute psychiatric signs & symptoms. May be displaying

Code	Service/Requirements	West Virginia
		symptoms & functional impairments such as impaired abilities in daily living skills, severe disturbances in conduct & emotions. Crisis results in emotional &/or behavioral instability which may be exacerbated by family dysfunction, transient situational disturbance, physical or emotional abuse, failed living situation, **and** Need of structured, intensive intervention because less restrictive services alone are not adequate or appropriate to resolve current crisis & meet member's needs based on documented response to prior TX &/or interventions. **or** Danger to Self/Others: Member is in need of intensive TX intervention to prevent hospitalization (e.g. self-injurious behavior but not at a level of severity that requires inpatient care, member is currently physically aggressive & communicates verbal threats but not at a level that requires hospitalization) **or** Medication Management/Active Drug or Alcohol Withdrawal: Member needs medication regimen that requires intensive monitoring/medical supervision or is being evaluated for a medication regimen that requires titration to reach optimum therapeutic effect **or** Evidence that member is using drugs, which have produced a physical dependency as evidenced by clinically significant withdrawal symptoms, which require medical supervision. <u>Continued stay:</u> Psychiatric Signs & Symptoms: Symptoms &/or functional impairments, persist at the level documented at admission &TXs & interventions tried are documented. Modified care plan must be developed which documents TX methods & projected discharge date based on the change in the care plan **or** New symptoms &/or functional impairments have been incorporated into care plan & modified discharge date. These new symptoms &/or functional impairments may be treated safely in this setting & less intensive LOC would not adequately meet member's needs. **or** Relevant progress toward crisis resolution & progress clearly & directly related to resolving the factors that warranted admission have been observed & documented, but TX goals have not been reached. Danger to Self/Others: Relevant progress toward crisis resolution & progress clearly & directly related to resolving the factors that warranted admission have been observed & documented, but TX goals have not been reached. **or** No progress toward TX goals nor has progress been made toward alternative placement (less or more restrictive care) but care plan has been modified to introduce further evaluation of member needs & other appropriate interventions & TX options. **or** New symptoms &/or functional impairments have been incorporated into care plan & modified discharge date. These new symptoms &/or functional impairments may be treated safely in this setting & less intensive LOC would not adequately meet member's needs. Medication Management/Active Drug or Alcohol Withdrawal: Member continues to require intensive monitoring/medical supervision of medication regimen or continues to require titration to reach optimum effect. **or**

Code	Service/Requirements	West Virginia
		Clinical withdrawal symptoms remain clinically significant as determined by a physician due to use of drugs, which have produced a chemical dependency & require medical supervision for detoxification. Other: Short-term crisis stabilization with 72 hr. service limit. Program must be available a minimum of 3 hrs/day, 7 days/wk. Must be a minimum of 2 staff members, 1 of which is clinically qualified professional. Program must have access to psychiatrist/physician and RN/LPN. Member must have psychiatric evaluation & initial crisis stabilization plan developed within 24 hrs. Not intended to be used for emergency response to running out of medication or housing problems.
	Coordination of Care Requirements	Discharge TX planning must include an assessment of antecedent conditions that caused need for the service. These conditions must be addressed to the agencies or agents who can modify them.
	Authorization/Review Frequency	288 units/per 10 days. Unit = 15 minutes. Tier 4 data submission for additional units after 10 days by provider previously utilizing benefit for same member. No more than 288 units may be provided in a 6 mo. period & no more than 48 units may be provided in a 24 hr. period. Each crisis admission within 184 day period considered a separate crisis episode. Tier 4 data submission required to exceed limit of 288 units/6mos. Maximum of 192 additional units in 10 calendar days authorized if specific number of units not requested.
	Documentation Requirements	Psychiatric evaluation, initial crisis stabilization plan within 24 hrs. Permanent clinical record consistent with licensing regulations & agency records/policies, including written orders for each crisis episode from the physician/psychiatrist, medication orders, medication administration records & member's individual service plan. Daily summary that describes milieu & each separate service provided to member, progress relative to objectives in service plan, member's status, & level of participation in service. Signature of the staff providing service, credentials, place & date of service, start/stop time. Daily schedule of program services & attendance records. Reason for admission, physician's signature (physician assistant or nurse practitioner with psychiatric certification) on the order & clinical note documenting specific need for services. Continued stay authorizations require Tier 4 data submission. Includes examples of billable & non-billable activities.

Appendix 3—UM Guidelines for Nebraska

Code	Service/Requirements	Nebraska
S9484	**23 Hour Crisis Observation, Evaluation, Holding, and Stabilization**	
	Diagnostic Criteria	Symptoms consistent with DSM-IV DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Symptoms consistent with DSM-IV DX & likely to respond to therapeutic intervention. Indications that symptoms may stabilize & alternative TX may be initiated within 23:59 hrs. Presenting crisis cannot be safely evaluated/managed in a less restrictive setting. Admission must be voluntary, **and at least one** of the following: Indication of actual/potential danger to self Command auditory/visual hallucinations or delusions leading to suicidal or homicidal intent. Indication of actual/potential danger to others Loss of impulse control leading to life-threatening behavior &/or other psychiatric symptoms requiring stabilization in structured psychiatrically monitored setting. Substance intoxication with suicidal/homicidal ideation. Abrupt or substantial change in normal life functioning Significant incapacitating or debilitating disturbance in mood &/or thought interfering with ADLs to the extent that immediate stabilization is required. Continued Stay: None Other: Up to 23:59 hrs. of care in secure, protected, medically staffed, psychiatrically supervised TX environment including continuous nursing services & on-site or on-call psychiatrist. Primary objective is prompt evaluation &/or stabilization of individuals presenting with acute psychiatric symptoms or distress. Comprehensive assessment completed & TX plan developed that emphasizes crisis intervention services necessary to stabilize & restore the individual to level of functioning not requiring hospitalization. May also be used for comprehensive assessment & to obtain classification regarding previously incomplete information that may lead to a determination that a more intensive level of care is required. 24-hrs./day, 7 days/week program. Services: pretreatment assessment, nursing, medication evaluation/management, psychiatric & psychological assessments, individual & group therapy Staffing: Supervising practitioner (psychiatrist; licensed clinical psychologist)**,** nursing**,** licensed therapists)**,** paraprofessionals (bachelor's degree in human services). **M**inimum therapist to

Code	Service/Requirements	Nebraska
		member ratio: 1:10. Minimum direct care staff to member ratio: 1:4 during waking hrs. & 1:6 during non-awake hours.
	Coordination of Care Requirements	Facilitation of appropriate TX & support linkages coordinated by TX team. Provider must coordinate discharge planning with ASO.
	Authorization/Review Frequency	1 time 23:59 hrs.
	Documentation Requirements	Biopsychosocial assessment, substance abuse screening, TX plan emphasizing crisis intervention & relapse prevention.
	Crisis Stabilization	
	Diagnostic Criteria	DSM DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Significant incapacitating or debilitating disturbance in mood/thought interfering with ADLs to extent that immediate stabilization is required. Active symptomatology consistent with a DSM DX which requires & can reasonably respond to intensive, structured intervention. Clinical evaluation indicates dramatic & sudden decompensation with strong potential for danger (but not imminently dangerous) to self/others & has no available supports to provide continuous monitoring. Individual requires 24-hour observation & supervision. Clinical evaluation indicates that individual can be effectively treated with short-term intensive crisis intervention services & returned to a less intensive level of care within a brief time frame. **and** A less intensive or restrictive level of care has been considered/tried or clinical evaluation indicates the onset of a life endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care. Continued stay: Condition continues to meet admission guidelines. TX does not require a more intensive LOC & no less intensive LOC would be appropriate. Care is rendered in a clinically appropriate manner & focused on behavioral & functional outcomes described in discharge plan. TX plan is individualized & appropriate to consumer's changing condition with realistic & specific goals for this LOC. All intervention& stabilization services & TX are specifically & carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. When medically necessary, appropriate psychopharmacological intervention has been prescribed &/or evaluated. **and** Documented active discharge, relapse & crisis prevention planning. Other: Facility-based program, continuous 24-hr. observation & supervision. Services: crisis stabilization, initial & continuing bio-psychosocial assessment, care management, medication management, & mobilization of family support & community

Code	Service/Requirements	Nebraska
		resources. May or may not be provided in a medical setting. Primary objective is to complete a comprehensive assessment & develop a TX plan with emphasis on crisis intervention services necessary to stabilize & restore a level of functioning which requires a less restrictive LOC. Staffing: supervising practitioner (psychiatrist), licensed psychologist, program director (APRN, RN w/master's in psychiatric nursing/counseling or related field, licensed mental health professional, 1 RN/shift, licensed therapists/counselors, case manager, psychiatric technicians.
	Coordination of Care Requirements	Facilitation of appropriate linkages coordinated by TX team.
	Authorization/Review Frequency	Typical length of stay 1-5 days as medically necessary
	Documentation Requirements	Initial assessment by licensed mental health professional prior to admission followed by comprehensive psychiatric evaluation by psychiatrist within 24 hrs., HX & physical within 24 hrs., alcohol & drug assessment, TX plan
H2012	**Partial Hospitalization**	
	Diagnostic Criteria	Primary Axis I or II DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Inability to maintain adequate level of functioning outside TX program due to a mental health disorder as evidenced by: • Severe psychiatric symptoms • Inability to perform ADLs • Failure of social/occupational functioning or failure &/or absence of social support resources. TX needed to reverse or stabilize condition requires frequency, intensity & duration of contact provided by a day program as evidenced by: • Failure to reverse/stabilize with less intensive TX accompanied by services of alternative delivery systems. • Need for specialized service plan for specific impairment. • Passive or active opposition to TX & risk of severe adverse consequences if TX not pursued. **and** Medical and mental health needs can be adequately monitored & managed by facility staff. Continued stay: Condition continues to meet admission criteria Individual does not require a more intensive level of care, & no less intensive level of care would be appropriate. as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement. Consumer is making progress toward goals & is actively participating in interventions. TX planning is individualized & appropriate to individual's changing condition with realistic & specific goals & objectives stated. All services & TX are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating &/or prescribing

Code	Service/Requirements	Nebraska
		appropriate psychopharmacological intervention. **and** Documented active discharge planning, including active relapse and crisis prevention planning. Other: May or may not be hospital-based. Diagnostic & TX services similar to inpatient program, but on less than 24-hr. basis May be used both as a transition to/from inpatient/residential LOC or as alternative to hospitalization or residential TX. Structured therapeutic milieu with minimum of 6 hrs./day of TX services (full day) or 3 hrs.TX services/day (half day). Minimum services: Individual therapy (minimum of 2-3 times/wk.), Group (daily), Family therapy (minimum of 2 times/wk), Recreation therapy (daily), Psycho-educational groups (daily). Program must be available a minimum of 5 days/wk, may be available 7 days/wk. Frequency of attendance may change based on individual needs. Length of stay is variable depending on presenting symptoms and DX. Staffing: Supervising practitioner (psychiatrist), licensed psychologist, program director (licensed clinician: LMHP, Ph.D., RN with master's degree in psychiatric nursing, counseling or mental health related field, psychiatrist), licensed therapist, RN available at all times, **c**ertified alcohol & drug addiction counselor (CADAC). Minimum staff to member ratio: 1:3. Minimum therapist to member ratio 1:8.Supervising practitioner must complete an initial diagnostic interview within 2 days of admission & provide face-to-face service at 4 out of 5 days.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Typical length of stay: 1-4 wks.
	Documentation Requirements	TX plan documentation: Member involvement &, when appropriate, his/her family in TX plan development, must be completed within 5 days & reviewed, updated & approved by TX team at least every 21days.
H2012, H2012 52, H2012 TU	**Day Treatment**	
	Diagnostic Criteria	Primary Axis I or II DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Inability to maintain adequate level of functioning outside TX program due to a mental health disorder as evidenced by: • Severe psychiatric symptoms that require medical stabilization. • Inability to perform ADLs. • Significant interference in at least 1 functional area (social, vocational/educational, etc.) • Failure of social/occupational functioning or failure &/or absence of social support resources. TX needed to reverse or stabilize client's condition requires frequency, intensity, & duration of contact provided by a day program as evidenced by: • Failure to reverse/stabilize with less intensive TX accompanied by services of alternative delivery systems.

Code	Service/Requirements	Nebraska
		• Need for a specialized service plan for a specific impairment. • Passive or active opposition to TX & risk of severe adverse consequences if TX not pursued. **and** Client's medical & mental health needs can be adequately monitored & managed by facility staff. <u>Continued stay:</u> Continues to meet admission guidelines. Does not require a more intensive LOC & no less intensive level of care would be appropriate. Reasonable likelihood of substantial benefit as a result of active continuation in therapeutic program, as demonstrated by objective behavioral measurements of improvement. Consumer is making progress toward goals & is actively participating in interventions. TX planning is individualized & appropriate to individual's changing condition with realistic & specific goals & objectives. All services & TX are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating &/or prescribing appropriate psychopharmacological intervention. **and** Documented active discharge planning, including relapse and crisis prevention planning. <u>Other:</u> Less intensive than partial hospitalization, for individuals who require more active TX/structure than traditional outpatient services. Provides coordinated set of individualized therapeutic services to persons who may be able to function in a normal school, work &/or home environment but are in need of therapeutic supports. May be used as transition from higher LOC or for those at risk of being admitted to a higher LOC. <u>Services:</u> Multidisciplinary biopsychosocial assessments and multimodal treatments, including, but not limited to initial diagnostic interview by psychiatrist/psychologist within 24 hrs., history and physical within 24 hrs, alcohol & drug assessment, rehabilitation readiness assessment, functional assessment, medication management, group therapy, individual psychotherapy, family therapy, and nursing, psychological, pharmacy, & dietary services. At least 2 of the following must also be provided: social skills building, life survival skills, substance abuse prevention, psycho-educational services, recreational therapy, speech therapy, occupational therapy, vocational skills therapy, or home based services/outreach. Minimum of 3 hrs./day (half day) or 6 hrs. (full day), 5 days/week. Frequency of attendance may change based on individual needs. Length of stay variable depending on presenting symptoms & DX. <u>Staffing:</u> **s**upervising practitioner (psychiatrist; licensed clinical psychologist)**,** program director (LMHP or RN with a master's degree in psychiatric nursing, counseling or related mental health field), licensed therapists, CADAC. Minimum program staff to member ratio: 1:6. Minimum therapist to member ratio: 1:12. Supervising practitioner must provide an initial diagnostic interview within 10 days of admission, provide face-to-face

Code	Service/Requirements	Nebraska
		service to member at least every 30 days, & be present in TX planning meetings at least every 30 days.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Typical length of service: 2-4 mos.
	Documentation Requirements	TX documentation: member involvement &, when appropriate, his/her family in TX plan development, must be completed within 10 days& reviewed, updated & approved by TX team at least every 30 days.
S9480	**Intensive Outpatient Service**	
	Diagnostic Criteria	Primary Axis I or II DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Individual's disorder can be expected to improve significantly through medically necessary & appropriate therapy. Consumer is only able to maintain adequate level of functioning outside TX program with this service intensity Significant symptoms that interfere with ability to function in at least 1 life area. **and** Consumer's medical & mental health needs can be adequately monitored & managed by facility staff. Continued stay: Continues to meet admission criteria Does not require a more intensive LOC, & no less intensive LOC would be appropriate. Reasonable likelihood of substantial benefit as a result of active continuation in program, as demonstrated by objective behavioral measurements of improvement. Consumer is making progress toward goals & actively participating in interventions. TX planning is individualized & appropriate to individual's changing condition with realistic and specific goals & objectives. All services & treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating &/or prescribing appropriate psychopharmacological intervention **and** Documented active discharge planning, including relapse & crisis prevention planning. Other: Provides coordinated set of individualized TX services to persons able to function in a school, work & home environment but are in need of TX services beyond traditional outpatient services. May be used for transition from higher LOCs or for persons at risk of being admitted to higher LOCs. Services: Multidisciplinary biopsychosocial assessments & multimodal treatments, including, but not limited to initial diagnostic interview by psychiatrist/psychologist prior to or at time of admission, alcohol & drug screening & assessment, individual/family/group therapy, medical education & monitoring. Minimum 2 hrs./day. Minimum 3 days/wk. Maximum of 5 days/wk. May be available 7 days/wk. TX plan reviewed every

Code	Service/Requirements	Nebraska
		2 wks. Staffing: supervising practitioner (psychiatrist, licensed clinical psychologist), program director (APRN, RN w/master's in psychiatric nursing/counseling or related field, psychologist), licensed therapists/counselors, Therapist to consumer ratio: 1:12. Supervision practitioner must do a direct service with consumer every 2 wks. & be available as needed & is clinically responsible for all TX. Access to licensed mental health professional 24/7.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Typically no longer than 3 mos. but as long as medically necessary
	Documentation Requirements	Initial TX plan within 2 sessions, master TX plan within 2 wks.
90862	**Medication Management**	
	Diagnostic Criteria	Valid principal Axis I or II DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Need for prescribing & monitoring psychotropic medications Admission guidelines for outpatient services Continued stay: Continues to meet admission criteria Other: Evaluation, provision, & monitoring of psychotropic medication & symptom management
	Coordination of Care Requirements	Service provider must make a good faith attempt to coordinate care with the individual's primary medical provider
	Authorization/Review Frequency	1 initial visit preauthorized, subsequent visits authorized via paper or online request. Routine retrospective reviews. Concurrent review by exception.
	Documentation Requirements	Not specified
H0040	**Assertive Community Treatment**	
	Diagnostic Criteria	SPMI
	Admission, Continued Stay, & Other Service Criteria	Admission: Persistent mental illness as demonstrated by presence of disorder for last 12 mos. or which is expected to last 12 mos. or longer & will result in a degree of limitation that seriously interferes with ability to function independently in an appropriate manner in 2 of 3 functional areas. Presence of functional deficits in 2 of 3 functional areas: vocational/education, social skills, ADLs • Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently & independently carry out home management tasks. • Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when

Code	Service/Requirements	Nebraska
		involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others. • ADLs: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in 3 of 5 of the following: 1) grooming, hygiene, washing clothes, meeting nutritional needs; 2) care of personal business affairs; 3) transportation & care of residence; 4) procurement of medical, legal, & housing services; or 5) recognition & avoidance of common dangers or hazards to self and possessions. Functional deficits of such intensity requiring extensive professional multidisciplinary treatment, rehabilitation & support interventions with 24 hour capability. Significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed treatment and rehabilitation services are not provided. History of high utilization of psychiatric inpatient & emergency services. **and** Less than satisfactory response to previous levels of treatment & rehabilitation interventions. <u>Continued stay:</u> Continues to meet admission guidelines. Does not require a more intensive level of services & no less intensive LOC is appropriate. Reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas. **and** Progress towards TX & rehabilitation goals is being made. <u>Other:</u> Self-contained clinical team which assumes clinical responsibility for directly providing comprehensive & integrated TX, rehabilitation and support services to consumers with severe disability due to SPMI. <u>Services:</u> Comprehensive, multidisciplinary biopsychosocial assessments- initial & ongoing. TX plan & crisis/relapse prevention plan within 21 days of assessment. Crisis intervention & response. Multidisciplinary integrated TX, rehabilitation & support plan coordination. Individualized TX, rehabilitation & support interventions. Medical assessment, management & intervention. Individual/family/group psychotherapy or substance abuse counseling. Medication (prescription, preparation, delivery, administration & monitoring). Psychoeducational services. Rehabilitation services including symptom management, skill development (pre-vocational, daily living, social, interpersonal, leisure). Supportive interventions including direct assistance & coordination in obtaining basic necessities (medical, housing, social services, transportation, etc.), in vivo support on personal goals, family support/education & consultation, & positive peer role modeling. Clinical supervision. Daily treatment team meetings. Ongoing assessment, TX & service planning meetings. Provision of service intensity to meet individualized consumer needs Meets standards for national accreditation.

Code	Service/Requirements	Nebraska
		Acquires & maintains accreditation. Staffing: Team psychiatrist (meets FTE standards/consumers served on team), team leader (master's degree in nursing, social work, psychiatric rehabilitation, psychology), psychiatrist, physician's assistant, mental health professionals (minimum 1), Additional staff: licensed mental health professional or RN or mental health worker, support staff. Team/client ratio of 1:70. Team member to client ratio 1:8. Hours of operation: 24/7 including weekends, evenings, holidays. Minimum 12 hr/day, 8hrs/day on weekends/holidays.
	Coordination of Care Requirements	Individual TX, rehabilitation, & recovery plan coordination is an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate TX, rehabilitation, & support services to a client in a planned, coordinated, efficient & effective manner. With the client's permission the ACT team involves pertinent agencies & members of the client's family & social network in the formulation of individual TX, rehabilitation, & recovery plans. Team is responsible for coordinating services with other providers.
	Authorization/Review Frequency	Up to 365 days/yr. based on individual need
	Documentation Requirements	Initial individual TX, rehabilitation, & recovery plan must be developed upon admission to ACT. A Comprehensive individual TX, rehabilitation, & recovery plan must be developed for each client within 21 days of the completion of the comprehensive assessment. This plan is developed through an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate TX, rehabilitation, & support services to the client in a planned, coordinated, efficient & effective manner. The comprehensive individual TX, rehabilitation, & recovery plan provides a systematic approach for meeting a client's needs, TX rehabilitation, & support needs, & documenting progress on TX, rehabilitation, & service goals. The following key areas must be addressed in the plan based upon individual needs of the client: symptom stability, symptom management & education, housing, ADLs, employment & daily structure, family & social relationships, & crisis support. The plan must be developed in collaboration with the client &/or guardian, if any, &, when appropriate, the client's family, &: • Identify the client's needs & problems; • List specific long & short term goals with specific measurable objectives for these needs & problems; • List the specific TX & rehabilitative interventions & activities necessary for the client to meet these objectives & to improve his/her capacity to function in the community; **and** • Identify the ACT Team members who will be providing the intervention. The client's participation in the development of the plan must be documented. The plan must be signed by the client & the team psychiatrist. The ACT team must review & revise the Individual TX, Rehabilitation, & Recovery Plan every 6 mos.,

Code	Service/Requirements	Nebraska
		whenever there is a major decision point in the course of TX, or more often if necessary. The team psychiatrist, team leader, & appropriate ACT team staff must participate in each review. The ACT team must include the client in the review. Guardians &/or family members should be encouraged to participate, as allowed by the client. The review must be documented in the client's clinical record, & include a description of progress & functioning since the last review, current functional strengths & limitations, a list of attendees, the discussion related to the plan, & any changes to the plan. The plan & review will be signed by the client & the team psychiatrist. The signature of the team psychiatrist indicates this is the most appropriate LOC for the client & that the TX, rehabilitative, & service interventions are medically necessary. Clinical records for ACT services must include: • Client identifying & demographic information • Assessments & evaluations • Team psychiatrist's orders • TX, rehabilitation & service planning • Current medications • Progress & contact notes must be recorded by all ACT Team members providing services to the client • Reports of consultations, laboratory results, & other relevant clinical & medical information • Documentation of involvement of family & other significant others • Documentation of transition & discharge planning • Documentation of discharge from the ACT program must be included.
H2018 TG	**Psychiatric Residential Rehabilitation**	
	Diagnostic Criteria	SPMI
	Admission, Continued Stay, & Other Service Criteria	Admission: Persistent mental illness as demonstrated by presence of the disorder for the last 12 mos. or which is expected to last 12 mos. or longer & will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in 2 of 3 functional areas. Presence of functional deficits in 2 of 3 functional areas: vocational/education, social skills, & ADLs. • Vocational/education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently & independently carry out home management tasks. • Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent

Code	Service/Requirements	Nebraska
		participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others. • ADLs: inability to consistently perform the range of practical daily living tasks required for basic adult functioning in 3 of 5 of the following: 1) grooming, hygiene, washing clothes, meeting nutritional needs; 2) care of personal business affairs; 3) transportation & care of residence; 4) procurement of medical, legal, & housing services; or 5) recognition & avoidance of common dangers or hazards to self & possessions. Functional deficits of such intensity requiring professional interventions in a 24 hour psychiatric residential setting. The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed residential rehabilitation services are not provided. <u>Continued stay:</u> Continues to meet admission guidelines. Does not require a more intensive level of services & no less intensive LOC is appropriate. Reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas. **and** The individual is making progress towards rehabilitation goals. <u>Other:</u> 24-hr. psychiatric rehabilitation, support & supervision in a community setting for individuals disabled by SPMI & who are unable to reside in a less restrictive setting due to the pervasiveness of the impairment. Services are designed to increase functioning to enable successful living in the residential setting of choice, capabilities & resources, & decrease frequency & duration of hospitalizations. <u>Services:</u> Comprehensive mental health & substance abuse screening &/or evaluation prior to admission. Strength-based psychosocial needs assessment within 30 days. Rehabilitation & support plan within 30 days. Supportive services, referral, problem identification/solution, service coordination. Individual Service Plan developed with consumer. Ongoing assessment. Minimum 25 hrs/wk. of on-site psychosocial rehabilitation activities& skill acquisition Programming focused on relapse prevention, nutrition, daily living skills, social skill building, community living, substance abuse, medication education & self-administration,& symptom management. Pre-vocational, educational & vocational focus as needed. Minimum of 20 hrs/wk. of additional off-site rehabilitation, vocational & educational activities. <u>Staffing:</u> Program Manager (LMHP, psychologist, RN with masters in psychology, nursing or related field). Direct care staff with bachelor's degree or higher in psychology, sociology, related field or equivalent course work & 2 yrs. experience in

Code	Service/Requirements	Nebraska
		working with clients with mental illness or substance abuse issues. Appropriate staff coverage to provide services for clients remaining in the residence during the day. Staff to client ratio days: 1:4. night hrs. 1:10 awake staff with on-call staff available.
	Coordination of Care Requirements	Service coordination & arranges for general medical, psychopharmacological and psychiatric services as necessary
	Authorization/Review Frequency	6-18 mos., average length of stay: 12 mos.
	Documentation Requirements	Not specific
H2017 H2018	**Day Rehabilitation**	
	Diagnostic Criteria	SPMI
	Admission, Continued Stay, & Other Service Requirements	Admission: Persistent mental illness as demonstrated by the presence of the disorder for the last 12 mos. or which is expected to last 12 mos. or longer & will result in a degree of limitation that seriously interferes with client's ability to function independently in an appropriate manner in 2 of 3 functional areas. Presence of functional deficits in 2 of 3 functional areas: vocational/education, social skills, & ADLs. • Vocational/education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently & independently carry out home management tasks. • Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others. • ADLs: inability to consistently perform the range of practical daily living tasks required for basic adult functioning in 3 of 5 of the following: 1) grooming, hygiene, washing clothes, meeting nutritional needs; 2) care of personal business affairs; 3) transportation & care of residence; 4) procurement of medical, legal, & housing services; or 5) recognition & avoidance of common dangers or hazards to self & possessions. Functional deficits of such intensity requiring professional interventions in a structured day setting **and** The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed rehabilitation services are not provided. Continued stay: Continues to meet admission guidelines. Does not require a more intensive level of services & no less intensive LOC is appropriate.

Code	Service/Requirements	Nebraska
		Reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas **and** The individual is making progress towards rehabilitation goals. Other: Rehabilitation & support services in a day program setting for persons disabled by SPMI. Individuals receive services designed to develop and maintain skills & functioning needed to successfully live in the community. Strength-based psychosocial needs assessment within 30 days. Rehabilitation & support plan within 30 days. Adult daily living skills development. Social skills development through planned socialization & recreational activities. Psycho-educational programming. Skill-building in use of transportation &/or access to transportation Supportive services, referral, problem identification/solution. Pre-vocational services. Individual service plan developed with consumer. Relapse & crisis prevention plan. Ongoing assessment. Services available minimum of 5 hrs/day, 5 days/wk. including weekend & evening hrs. Programming focused on relapse prevention, nutrition, daily living skills, social skill building, community living, substance abuse, medication education & self-administration, & symptom management. Pre-vocational, educational & vocational focus as needed. Meet all food handling, storage & processing requirements. Rehabilitation & TX team meetings. Weekly to monthly review/adjustment of TX & rehabilitation plans to meet medical & rehabilitative needs of each client. Staffing: Clinical supervision (LMHP, psychologist, RN with master's degree in psychiatric nursing, psychology or related field. Direct care staff have minimum bachelor's degree or post-high school coursework in psychology or related field & 2 yrs. experience in the delivery of mental health services. Consultation by licensed professionals on general medical, dietary, chemical dependence, pharmacology & psychiatric issues. Staff to client ratio direct care staff minimum 1:6. Hours of operation: regularly scheduled evening & weekend hrs. Consumer has access to licensed mental health provider 24/7.
	Coordination of Care Requirements	Service coordination (primary coordination with all physicians & medical services)
	Authorization/Review Frequency	Length of stay: 16-24 mos.
	Documentation Requirements	Not specific
H2016 HE	**Community Support**	
	Diagnostic Criteria	SPMI
	Admission, continued Stay, & Other Service Criteria	Admission: Persistent mental illness as demonstrated by the presence of the disorder for the last 12 mos. or which is expected to last 12 mos. or longer and will result in a degree of limitation that seriously interferes with client's ability to function independently in an appropriate manner in 2 of 3 functional areas.

Code	Service/Requirements	Nebraska
		Presence of functional deficits in 2 of 3 functional areas: vocational/education, social skills, & ADLs. • Vocational/education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently & independently carry out home management tasks. • Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others. • ADLs: inability to consistently perform the range of practical daily living tasks required for basic adult functioning in 3 of 5 of the following: 1) grooming, hygiene, washing clothes, meeting nutritional needs; 2) care of personal business affairs; 3) transportation & care of residence; 4) procurement of medical, legal, & housing services; or 5) recognition & avoidance of common dangers or hazards to self & possessions. Client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed rehabilitation services are not provided. <u>Continued stay:</u> Continues to meet admission guidelines. Does not require a more intensive level of services & no less intensive LOC is appropriate. Reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas. **and** The individual is making progress towards rehabilitation goals. <u>Other:</u> Rehabilitative service for individuals disabled by SPMI. Generally provided in the client's place of residence or related community locations. Skilled paraprofessionals provide direct rehabilitation & support services & interventions & assist in developing services necessary to maintain community living & prevent exacerbation of illness & admission to higher LOCs. Comprehensive strength-based psychosocial assessment within 30 days. Collect information & develop individual program/service plan within 30 days. Direct provision of active rehabilitation & support interventions with focus on: ADLs, education, budgeting, medication compliance & self-administration, relapse prevention, social skills, & independent living skills. Participation in & reporting to TX/rehabilitation team on progress in areas of medication compliance, relapse prevention, social skill acquisition & application, education & substance use/abuse. Crisis/relapse prevention plan. Support & intervention in time of crisis. Crisis/relapse intervention &

Code	Service/Requirements	Nebraska
		involvement to transition consumer's return to community & avoid need for higher LOCs. Monitor medication compliance. Ongoing assessment, TX, rehabilitation & program/service plan meetings. Program/service plan reviewed/updated every 30 days Frequency of face to face contacts based upon need - estimate minimum of 3/mo. Access to staff for support, intervention, coordination during times of crisis. Clinical supervision of individual service plans Service delivery NOT provided during same service delivery hr. of other rehabilitation services. Approved service provision, as transition, 30 days post-admission or 30 days pre-discharge from inpatient/residential LOC to decrease length of stay & support continuity of care. Consultation by professionals licensed/credentialed by state on general medical, psychopharmacology, psychological issues, program design. Staffing: Direct care workers: BS in psychology, social work or related field & minimum of 1 yr. experience in direct care of consumers with SPMI or other mental health services. Bachelor's degree in another field with advanced education in psychology, social work, sociology or other related fields or an associate degree in human services or related field & minimum of 2 yrs. experience in direct services to persons with SPMI or other mental health services. Clinical supervision by licensed clinician with 3-5 yrs. experience in the delivery of mental health & substance abuse rehabilitation services. Therapist provides direction & supervision of individual service/program plan. Staff to client ratio caseload 1:20. Hours of operation 24/7. Access to service during weekend/evening hrs. or in time of crisis with mental health provider backup.
	Coordination of Care Requirements	Service coordination and case management activities including coordination or assistance in accessing medical, social, education, housing, transportation, or other appropriate support services as well as linkage to more/less intensive community services. Facilitate communication between TX & rehabilitation providers & with primary/supervision practitioner.
	Authorization/Review Frequency	Average length of stay: 12 mos. or as long as medically necessary
	Documentation Requirements	Program follows agency's written policy & procedures regarding clinical records. Policies must include specifics about timely record entry by all professionals & paraprofessionals providing services. Clinical record must provide information that fully discloses the extent & outcome of TX/rehabilitation services provided to the client. It must be organized with complete legible documents. When reviewing a clinical record, a clinician not familiar with the client or the program must be able to review, understand & evaluate the mental health & substance abuse TX for the client. Record must record the date, time, & complete name & title of the facilitator of any TX service provided. All progress notes should contain the name & title of the author. To maintain 1 complete, organized clinical

Code	Service/Requirements	Nebraska
		record for each client served, the agency must have continuous oversight of the condition of the clinical record.
	Mental Health Home Health	
Varies depending on type/amount of service	**Diagnostic Criteria**	Psychological symptomatology consistent with ICD-9 & DSM DX
	Admission, Continued Stay, & Other Service Requirements	Admission: The individual demonstrates psychological symptomatology consistent with ICD-9 & most recent DSM DX which requires & will respond to therapeutic intervention. The individual is receiving TX services under a physician/psychiatrist. Stabilization of the individual's mental health condition requires mental health home based health services. Mental health home health nursing can be expected to allow the individual the best opportunity of stabilization of the mental health condition & is the least restrictive LOC for this individual. TX plan clearly identifies the types of services & interventions needed as a part of the mental health home health service. Continued stay: The individual is maintaining stability of his/her mental health condition. The individual is making progress as evidenced by improvement in the individual's symptoms, problems, & impairments. Mental health home health care remains the least restrictive level of intervention for this individual. The physician/psychiatrist has evaluated the client's progress by review of the TX plan & progress every 30 days. Other: Provided to clients in their place of residence. (place of residence does not include a hospital, skilled nursing facility, day rehab or residential rehab facility, or adult day treatment facility.) The home health service is provided by a licensed RN to clients who are unable to access office-based services. Service is necessary to continue & maintain a comprehensive plan of care. Service is only available to homebound. ("Homebound" is defined as an individual whose medical or psychiatric condition restricts their ability to leave home safely without the assistance or supervision of another individual or without the assistance of a supportive device & the patient leaves home only to receive medical/psychiatric treatment or leaves home infrequently for non-medical purposes.") Typically the client has a very poor support system, (no family or interested party to act as caretaker, family members or interested parties exist but have poor insight into the client's psychiatric condition & have no positive impact in assisting in the improvement of the client's psychiatric/medical condition). Services may include medication administration, assistance in setting up a medication system, teaching & monitoring of medication, & observation of the physical well-being in relation to medication side effects. Service is not intended to replace the

Code	Service/Requirements	Nebraska
		direct involvement of a physician/psychiatrist in the TX of the individual. Must provide or otherwise demonstrate that members have on-call access to a mental health provider 247. The pre-treatment assessment & additional nursing assessment conducted by appropriate practitioners working within their scope of practice will be completed prior to the initiation of services. A physician's order is required to initiate this service. Assessment should be ongoing, reviewed by the supervising practitioner, & documented. TX plan will be: • Developed following completion of required assessments. • Completed prior to the initiation of Mental Health Home Health services • Completed using measurable goals and objectives for TX • Include a reasonable discharge plan to include a plan for transitioning to community based mental health services • Be developed with the inclusion of the client, their family/significant others as appropriate, & the TX including the supervising practitioner The plan must be reviewed at least every 60 days, or more often as necessary, by the client, their family/significant others, other treatment team members, including the supervising practitioner. <u>Staffing:</u> Medical director – Licensed physician either employed or contracted who assures the overall medical service integrity of the service. If the medical director is not a psychiatrist, the agency must have an employed or contracted psychiatrist who serves as the supervising practitioner overseeing each individual's TX. Supervising practitioner – A psychiatrist who is responsible for each individual's TX plan & mental health home health services. Clinical program director - RN who has management abilities, experience in providing psychiatric services & at least 1 year experience in home health nursing. Responsible for management & administration of all mental health home health services for the agency. RNs – Must be licensed & have psychiatric experience.
	Coordination of Care Requirements	Service is intended to support & facilitate increased coordination with rehabilitation services such as community support services
	Authorization/Review Frequency	Frequency & duration of service varies based on individual client needs, but does not exceed 35 days in first 60-day authorization period & maximum of 12 days for each subsequent 60-day authorization period.
	Documentation Requirements	Agency must provide clinical records that fully describe services provided to client. Clinical record must contain the pre-treatment assessment & nursing assessment. Must include supervising practitioner orders & nurses progress notes reflecting services rendered with each contact with the client. It also must describe all case management & communication services with all other professionals involved in the client's

Code	Service/Requirements	Nebraska
		care. Updates/reviews of TX plan must be signed by all of those involved in the review.
H2018 HK	**Secure Residential Rehabilitation**	
	Diagnostic Criteria	Primary DSM DX
	Admission, Continued Stay, & Other Service Requirements	Admission: Moderate to high risk of danger to self as a product of principal DSM DX, as evidenced by any of the following: • Attempts to harm self, which are life threatening or could cause disabling permanent damages with continued risk without 24-hr. behavioral monitoring. • Suicidal ideation • Level of suicidality that cannot be safely managed without 24-hr. behavioral monitoring. • At risk for severe self-neglect resulting in harm or injury. Moderate to high risk of danger to others, as a product of principal DSM DX, as evidenced by any of the following: • Life threatening action with continued risk without 24-hr. behavioral supervision & intervention. • Harmful ideation Moderate to high risk of relapse or symptoms reoccurrence, as evidenced by the following (must meet all criteria): • Active symptomatology consistent with DSM DX • High need for professional structure, intervention & observation • High risk for re-hospitalization without 24-hr. **and** • Unable to safely reside in less restrictive residential setting & requires 24-hr. supervision. Continued stay: Valid DSM Axis I DX or co-occurring disorder that results in a pervasive level of impairment Reasonable likelihood of substantial benefit as a result of recovery/rehabilitation therapeutic activities that necessitates the 24-hr.secure care setting. Able to participate in recovery/rehabilitation/therapeutic activities. Achieve progress towards recovery goals. **and** Continuation of symptoms or behaviors that required admission, & the judgment that a less intensive LOC & supervision would be insufficient to safely support the individual. Other: Provides individualized recovery, psychiatric rehabilitation, & support as determined by a strengths based assessment for individuals with APMI &/or co-occurring substance abuse disorder demonstrating moderate to high risk for harm to self/others & in need of secure, recovery/rehabilitative therapeutic environment. History & physical within 24 hrs. of admission. May be accepted from previous provider if completed within last 3 mos. Initial diagnostic interview within 24 hrs. of admission by psychiatrist. Nursing assessment within 24 hrs. of admission. Other assessments as needed, & as needed on an ongoing basis

Code	Service/Requirements	Nebraska
		all of which should integrate mental health/substance abuse TX needs. Initial TX recovery plan completed within 24 hrs. of admission with psychiatrist as supervisor of clinical TX & direction. Multidisciplinary bio-psychosocial assessment completed within 14 days of admission. An individual recovery/discharge/relapse prevention plan developed with the individual & chosen supports' input (with informed consent) within 30 days of admission & reviewed weekly by the individual & recovery team. Integration of substance abuse & mental health needs & strengths in assessment, treatment/recovery plan, & programming. Consultation services available for general medical, dental, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory & other diagnostic services as needed Face-to-face with psychiatrist minimum of every 30 days or as often as medically necessary. 42 hrs. of active TX available/provided to each consumer weekly, 7 days/wk. Access to community-based rehabilitation/social services to assist in transition to community living. Medication management (administration & self-administration), & education. Psychiatric & nursing services. Individual, group, & family therapy & substance abuse TX as appropriate. Psycho-educational services including daily living, social skills, community living, family education, transportation to community services, peer support services, advance directive planning, self-advocacy, recreation, vocational, financial. Staffing: Medical director: psychiatrist with adequate time to meet service requirements, licensed program director, direct care staff: bachelor's degree or higher or 2 yrs. course work in human services field, & 2 yrs. experience/training or 2 yrs. of lived recovery experience with demonstrated skills & competencies in TX with individuals with a mental health DX. Licensed therapist, 24 hr. nursing. Staff ratios: 1 direct care staff to 4 clients during client awake hrs.; 1 awake staff to 6 clients with on-call availability of additional support staff during client sleep hrs.; access to on-call, licensed mental health professionals 24/7. Appropriate staff coverage to provide a variety of recovery/rehabilitative, therapeutic activities & groups throughout weekdays & weekends. RN/client ratio sufficient to meet client care needs, Therapist to consumer, 1 to 8. Peer Support to consumer, 1 to 16 if available
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Individualized
	Documentation Requirements	Not specified except as noted above
H0046	**Customer Assistance Program (CAP)**	
	Diagnostic Criteria	None
	Admission Continued Stay, & Other Service Criteria	No specific admission or continued stay criteria. CAP offers short-term, solution-focused interventions provided by a licensed professional & aimed at assisting the individual

Code	Service/Requirements	Nebraska
		&/or family presenting with stressors that are interfering with daily living & general well-being. It is an early intervention approach to dealing with those problems before they become unmanageable. CAP is intended to provide assistance to individuals & families for whom long-term intervention does not appear to be needed. No DX is necessary to receive this service. Services begin with a brief assessment of the presenting problem & the appropriateness of the use of CAP services to alleviate the problem. One of the primary objectives of the service is to empower the individual or family to reach a more manageable level of functioning.
	Coordination of Care Requirements	Referral for more intensive mental health/substance abuse services after 5 visits as needed.
	Authorization/Review Frequency	Limited to 5 visits/yr.
	Documentation Requirements	Intervention plan developed at first CAP session & reviewed at each subsequent session.
90804	**Outpatient Individual Psychotherapy**	
	Diagnostic Criteria	Symptoms consistent with DSM DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Symptomatology consistent with a DSM DX which requires & can reasonably be expected to respond to therapeutic intervention. Significant symptoms that interfere with the individual's ability to function in at least 1 life area. **and** An expectation that the individual has the capacity to make significant progress toward treatment goals. Continued Stay: Continues to meet admission guidelines at this LOC. TX does not require a more intensive LOC, & no less intensive LOC would be appropriate. TX planning is individualized & appropriate to the individual's changing condition, with realistic & specific goals & objectives clearly stated. All services & TX are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Progress in relation to specific symptoms or impairments is clearly evident & can be described in objective terms, but goals of TX have not yet been achieved, or adjustments in the TX plan to address lack of progress are evident. Care is rendered in a clinically appropriate manner & focused on the individual's behavioral & functional outcomes as described in the discharge plan. When medically necessary, appropriate psychopharmacological intervention has been prescribed &/or evaluated. **and** There is documented active discharge planning. Other: Services may be provided in an office, clinic or other professional service environment. May be provided in client's home under specific conditions of need. ("Homebound" is defined as an individual whose medical or psychiatric condition restricts their ability to leave home safely without the assistance

Code	Service/Requirements	Nebraska
		or supervision of another individual or without the assistance of a supportive device.) Service provider must provide or otherwise demonstrate that members have on-call access to a mental health provider 24/7. Comprehensive bio-psychosocial assessment must be completed prior to the beginning of treatment &: • Initial diagnostic interview must be conducted by physician (psychiatrist preferred), psychologist, or licensed mental health professional prior to beginning TX • Assessment should be ongoing with TX. • Individualized TX/recovery plan, including discharge & relapse prevention, developed with the individual prior to beginning TX (consider community, family & other supports), reviewed on an ongoing basis, & adjusted as medically indicated. • Assessments & TX should address mental health needs, & potentially, other co-occurring disorders • Provided as individual psychotherapy • Consultation &/or referral for general medical, psychiatric, & psychopharmacology needs. <u>Staffing</u>: Licensed provide this service Supervising practitioner responsibilities: • Provide face-to-face service to the member at least annually or as often as medically necessary. • Meet with the client face-to-face to complete the initial diagnostic interview • Review the biopsychosocial assessment completed by the therapist. • Complete the initial diagnostic interview which includes a summary of the chief complaint, a history of the mental health condition, a mental status exam, formulation of a DX & the development of a plan. • Provide the therapist an individualized narrative document that includes all of the components of the initial diagnostic interview & recommendations for TX if ongoing TX is necessary • Provide a supervisory contact with the provisionally licensed therapist every 30 days or more often as necessary, & every 90 days for the fully licensed therapist, or more often as necessary. Direct face-to-face contact is preferred; however, communication may occur by telephone. Supervisory contact will include: ✓ Review of TX recommendations developed in the pretreatment assessment by the therapist & the supervising practitioner. ✓ Update on the status of the client, including progress achieved, barriers that impaired movement in TX, to include any critical incidents which involve safety to self/others. ✓ Review of the TX/recovery plan & progress

Code	Service/Requirements	Nebraska
		notes provided by the therapist. ✓ Determination of plan for ongoing TX, with any change in focus or direction of TX. ✓ Review of the discharge plan & recommendation for changes in discharge as necessary. ✓ Changes in the discharge plan are documented in the client's clinical record.
	Coordination of Care Requirements	Provider is responsible for coordinating with other treating professionals.
	Authorization/Review Frequency	24 sessions over 6 mos. Reauthorization: 24 sessions over 6 mos. Additional 12 sessions with review by care manager.
	Documentation Requirements	Complete clinical record of client's mental health condition including pretreatment assessment, assessment updates, master TX/recovery & discharge plan & TX/recovery & discharge plan updates, therapy progress notes, complete record of supervisory contacts, narratives of others' case management functions, & other information as appropriate.
90853	**Outpatient Group Psychotherapy**	
	Diagnostic Criteria	Symptomatology consistent with DSM DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Symptomatology consistent with a DSM DX which requires & can reasonably be expected to respond to group therapeutic intervention. Individual participant has an interpersonal problem related to their DX & functional impairments. An expectation that the individual has the capacity to make significant progress toward TX from interaction with others who may have a similar experience. Individual has the competency to function in a group therapy. Individual has a therapeutic goal common to the group. **and** Individual may benefit from confrontation by &/or accountability to a group of peers. Continued Stay: Individual's condition continues to meet admission guidelines at this LOC. Individual's TX does not require a more intensive LOC & no less intensive LOC would be appropriate. TX planning is individualized & appropriate to the individual's changing condition, with realistic & specific goals & objectives clearly stated. All services & TX are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Progress in relation to specific symptoms or impairments is clearly evident & can be described in objective terms, but goals of TX have not yet been achieved, or adjustments in the TX plan to address lack of progress are evident. Care is rendered in a clinically appropriate manner & focused on the individual's behavioral & functional outcomes as described in the discharge plan. **and** Documented active discharge planning. Other:

Code	Service/Requirements	Nebraska
		May be provided in an office, clinic or other locations appropriate to the professional provision of group psychotherapy in groups of at least 3 & no more than 12 clients. Typical business hours are expected, with weekend & evening hours available to provide this service by appointment. Service must provide or otherwise demonstrate that members have on-call access to a mental health provider 24/7. Multiple therapies may need to be coordinated with the ASO. Staffing: Same as for outpatient psychotherapy
	Coordination of Care Requirements	Same as for outpatient psychotherapy
	Authorization/Review Frequency	Same as for outpatient psychotherapy
	Documentation Requirements	Same as for outpatient psychotherapy
90847	**Outpatient Family Psychotherapy**	
	Diagnostic Criteria	Behavioral health/substance abuse condition
	Admission, continued Stay, & Other Service Criteria	Admission: Involve the individual & his/her family with a therapist for the purpose of changing a behavioral health/substance abuse condition focusing on the level of family functioning as a whole & address issues related to the entire family system. **and** Family therapy is recommended by the assessment as medically necessary to achieve goals/objectives for TX of a behavioral health/substance abuse condition. Continued Stay: Admission guidelines continue to be met. TX planning is individualized & appropriate to the family's changing condition, with realistic & specific goals & objectives clearly stated. All services & TX are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Progress in relation to specific dysfunction is clearly evident & can be described in objective terms, but goals of TX have not yet been achieved, or adjustments in the TX plan to address lack of progress are evident. Care is rendered in a clinically appropriate manner & focused on the family's behavioral & functional outcomes as described in the discharge plan. **and** Documented active discharge planning. Other: May be provided in an office, clinic or other professional service environment. Weekend & evening hours should be available by appointment. May be provided in the family's home under specific conditions of need. Service must provide or otherwise demonstrate that members have on-call access to a licensed mental health provider 24/7. May be conducted in addition to other outpatient therapy services as appropriate with documentation showing coordination of all services in the TX record, & reviews by the supervising practitioner. 1 family psychotherapy session/day. 1 family psychotherapy session for families even though the family may have multiple Medicaid

Code	Service/Requirements	Nebraska
		eligible members with a psychiatric &/or substance abuse disorder. Only 1 Medicaid eligible family member may be billed even though another identified Medicaid eligible member may be present in the session. Must be a 60-minute session, at a minimum. Staffing: Same as for outpatient psychotherapy
	Coordination of Care Requirements	Therapists of families with more than 1 mental health/substance abuse provider must communicate with & document coordinated services with any other mental health/substance provider for the family or individual family members.
	Authorization/Review Frequency	Same as for outpatient psychotherapy.
	Documentation Requirements	Complete clinical record of the family's TX. The clinical record will contain the pretreatment assessment (including detailed family assessment), the master TX plan & TX plan updates, family therapy progress notes that identify goals of the TX & discharge plan, a complete record of supervisory contacts, narratives of other case management functions, case coordination, & other information as appropriate & relates to the family's TX. Each progress note must include every family member involved in session, the date & start/end time of each family session.

Appendix 4—UM Guidelines for Iowa

Code	Service/Requirements	Iowa
H0035	**23 Hour Crisis Observation, Evaluation, and Stabilization**	
	Service Description	Provides up to 23 hrs., 59 minutes of care in a secure, protected, medically staffed, psychiatrically supervised, TX environment for individuals in crisis, danger/potential danger to self or others. Appropriate medical services available. The family & all active caregivers, including mental health & addiction TX professionals & PCPs, have immediate involvement in evaluation, service planning, & TX as appropriate. Active discharge planning. Staffing: board-eligible or board-certified psychiatrist, RNs, psychologists, social workers, & ancillary staff available as needed.
S9485	**Crisis Stabilization**	
	Service Description	Provides continuous 24-hr. observation & supervision for members who do not require intensive TX in an inpatient psychiatric setting & would benefit from a short-term, structured stabilization setting. Services include crisis stabilization, initial & continuing assessment, care management, medication management, & mobilization of family support & community resources. Evaluation by licensed mental health professional at admission &discharge. Evaluation/consultation by psychiatrist available as clinically indicated. Immediate involvement of family & all active pre-hospitalization caregivers, including addiction TX professionals & PCPs, in evaluation, service planning, & TX as appropriate.
S9485	**Mobile Crisis Services**	
	Service Description	Focused assessment & rapid stabilization of acute symptoms of mental illness or emotional distress. Provided in various community settings. 24/7 phone access. Diagnostic interview, risk assessment, mental status exam, family evaluation, record review, involvement of family members & other professionals, as appropriate. Disposition plan. Staffing: provided by licensed mental health professional with immediate access to psychiatric consultation.
H0035	**Partial Hospitalization**	
	Service Description	Active TX program providing intensive group & individual clinical services within a structured therapeutic environment for individuals who are exhibiting psychiatric symptoms of sufficient severity to cause significant impairment in day-to-day functioning. Short-term outpatient crisis stabilization & rehabilitation services are provided to avert hospitalization or to transition from an acute care setting. Services enable individuals to remain in their community living situation through the receipt of therapeutically intensive milieu services. Individuals using the service & staff mutually develop an individualized service plan that focuses on the behavioral, mental

Code	Service/Requirements	Iowa
		health issues, & problems identified at admission. Goals are based on the individual's need for services. Comprehensive schedule of active, planned, & integrated psychotherapeutic & rehabilitation services. Group & individual TX services designed to increase the member's ability to function independently. Individuals using the service are involved in the development of an anticipated discharge plan that includes linkages to family, provider, & community resources & services. Services are commensurate with current identified risk & need factors. Support systems identified by the member are involved in planning & provision of services & TX as appropriate & desired by the member. The member participates in developing a detailed psychiatric crisis intervention plan that includes natural supports & self-help methods. <u>Staffing:</u> Services supervised & managed by a mental health professional. A licensed & qualified psychiatrist provides psychiatric consultation & medication services. Clinical services provided by a mental health professional. Sufficient staff available to ensure safety, to be responsive to crisis or individual need, & provide active TX services. Criteria include a reasonable likelihood of substantial benefit of program participation as demonstrated by objective behavioral measurements of improvement.
H2012	**Day Treatment**	
		An individualized service emphasizing mental health TX & intensive psychosocial rehabilitation activities designed to increase the individual's ability to function independently or facilitate transition from residential placement. Staff use individual & group TX & rehabilitation services based on individual needs & identified behavioral or mental health issues. Individuals using the service who are experiencing a significantly reduced ability to function in the community are stabilized & improved by the receipt of psychosocial rehabilitation, mental health TX services, & in-home support services, & the need for residential or inpatient placement is alleviated. Individuals participate with the staff in identifying the problem areas to be addressed & goals to be achieved that are based on the individual's need for services. Individuals using the service receive individualized services designed to focus on those identified mental health or behavioral issues that are causing significant impairment in their day-to-day functioning. Comprehensive & integrated schedule of recognized individual & group TX & rehabilitation services. Progress in resolving problems & achieving goals is reviewed by the individual & staff on a frequent & regular basis. Services appropriate to defined needs & current risk factors or

Code	Service/Requirements	Iowa
		disabilities. Individuals participate in discharge planning that focuses on coordinating & integrating individual, family, & community & organization resources. Family members of individuals using the service are involved in the planning & provision of services, as appropriate & as desired by the individual. Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports & self-help methods. Service components include training in independent functioning skills necessary for self-care, emotional stability, & psychosocial interactions, & training in medication management. Services are structured with an emphasis on program variation according to individual need. Services may be provided for a period of 3 to 5 hours per day, 3 or 4 times/wk. Staffing: A mental health professional provides or directly supervises the provision of treatment services. Board-eligible or board-certified psychiatrist, a staff psychiatrist, or a psychologist must develop TX plan that states type, amount, frequency, & duration of the service & the anticipated goals.
S9480	**Intensive Outpatient**	
	Service Description	Modalities include consumer skills training, group & family therapy, medication management, relapse prevention training, psychoeducation, & coordination of psychosocial resources. Assessment, service plan & discharge plan, Minimum of 9 hrs. of active TX/wk. Staffing: Psychiatric & medical consultation available. Licensed psychiatrist, a psychologist, or licensed mental health professional must supervise all services. Licensed clinicians authorize & review services provided by non-licensed clinicians & co-sign documentation. Psychiatrist & licensed mental health professional on call 24/7.
Varies depending on specific service type	**Outpatient Services**	
	Service Description	A dynamic process in which the therapist uses professional skills, knowledge & training to enable individuals using the service to realize & mobilize their strengths & abilities, take charge of their lives, & resolve their issues & problems. May be individual, group, or family. Individuals using the service realize & mobilize their own strengths & abilities to take control of their lives in the areas where they live, learn, work, & socialize. Individuals using the service are prepared for their role as partners in the therapeutic process at intake where they define their situations & evaluate those factors that affect their situations. Individuals using the service establish desired problem resolution at intake during the initial assessment. Psychiatric services & psychopharmacological services are available as needed.

Code	Service/Requirements	Iowa
		Individuals who have a chronic mental illness participate in developing a detailed psychiatric crisis intervention plan that includes natural supports & self-help methods. Staffing: Provided by a mental health professional or by staff with a master's degree or an intern working on a master's degree in a mental health field who is directly supervised by a mental health professional.
	Coordination of Care Requirements	Not specified.
	Authorization/Review Frequency	Outpatient services reviewed by exception
	Documentation Requirements	Staff document mutually agreed-upon treatment goals, supports, & interventions during or after each session. Progress notes include the individual's status at each visit & reasons for continuing or discontinuing services. Any assignment of activities to occur between sessions is documented in the following session's documentation. The record documents follow up on individuals who miss appointments.
96100	**Psychological Testing**	
	Service Description	Psychological examination and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress not to exceed eight hours in any 12-month period. May include communication with family or other sources or ordering & medical interpretation of laboratory or other medical diagnostic studies. Administered by licensed doctoral-level psychologist or other qualified provider as permitted by Iowa regulations. Must be provided face-to-face. Mileage may be reimbursed under specific circumstances. Limited to 8 hours (32 units) of service in a 12-month period.
H2014	**Skill Training & Development**	
	Service Description	Includes interventions to enhance independent living, social & communication skills that minimize or eliminate psychological barriers to a member's ability to manage symptoms associated with a psychological disorder effectively & maximize the member's ability to live & participate in the community. Interventions may include the following skills for effective functioning with family, peers, & community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, & employment-related skills. Focus of intervention is to improve individual's health and well-being related to specific DX related problems & enhance the individual's mental health recovery by increasing abilities in symptom management & relapse prevention. Requires a Remedial Services Implementation Plan that is consistent with the TX plan recommended by licensed practitioner. Provider must review the plan every 6 months of more frequently if warranted. Services may be provided to individuals only, may be provided in a group setting, however, services must be individualized & provided directly to the individual. Authorization every 6 months by state Medicaid agency.
H0040	**Assertive Community**	

Code	Service/Requirements	Iowa
	Treatment	
	Diagnostic Criteria	SPMI or complex mental health symtomotology
	Eligibility Criteria	At least 17 years old Lack of resources or skills needed to maintain adequate level of functioning in the community without assistance or support Judgment/impulse control/&/or cognitive skills are compromised. Significant impairment in social, interpersonal, or familial functioning Need for a consistent team of professionals & multiple mental health & support services to maintain member in the community & reduce need for hospitalization as evidenced by: • History of TX failures & at least 2 hospitalizations in last 24 mos. **or** • Need for multiple or combined mental health & basic living supports to prevent need for more intensive LOC Medically stable Does not need LOC that provides more intensive medical monitoring Low risk to self/others/property Member lives independently in the community or demonstrates capacity to transition to independent living. Other: Primary DX of substance abuse or developmental disability not eligible for ACT. Services: Evaluation & medication management & monitoring, integrated therapy & counseling for mental health & substance abuse, skill teaching, community support, case management. Referrals & related activities, monitoring & follow-up, crisis response, work-related services. Services available 24/7. Staffing: At a minimum, team consists of RN, mental health service provider, & substance abuse TX professional under clinical supervision of a psychiatrist. May include psychologist, peer specialists, community support specialists, case managers, physician assistants. Team members must have experience with adults with SPMI. Daily team meetings.
	Coordination of Care Requirements	Team coordinates all behavioral health services except drugs & hospitalization.
	Authorization/Review Frequency	Every 180 days
	Documentation Requirements	Written TX plan including objectives & outcomes, expected duration & frequency of each service, service location, crisis plan, & schedule for TX plan updates.
H2017	**Intensive Psychiatric Rehabilitation**	
	Service Description	Services designed to restore, improve, or maximize level of functioning, self-care, responsibility, independence, & quality of life; to minimize impairments, disabilities, & disadvantages of people who have a disabling mental illness; & to prevent or reduce need for services in a hospital or residential setting. Services focus on improving personal capabilities while reducing harmful effects of psychiatric disability, resulting in an individual's recovering the ability to perform a valued role in

Code	Service/Requirements	Iowa
		society. Includes readiness assessment, readiness development, goal-choosing, & goal-achieving phases. Staffing: Must be provided intensive psychiatric rehabilitation practitioner. Supervisor must have minimum of bachelors' degree & 60 hrs. training in intensive psychiatric rehabilitation.
H0037	**Community Support**	
	Service Description	Services provided at two levels of intensity. Provided to individuals with a mental illness to enable them to develop supports & learn skills that will allow them to live, learn, work & socialize in the community. Services are individualized, need- & abilities-focused, & organized according to the following components: outreach to appropriate support or TX services; assistance & referral in meeting basic human needs; assistance in housing & living arrangements; crisis intervention & assistance; social & vocational assistance; provision of or arrangement for personal, environmental, family, & community supports; facilitation of the individual's identification & development of natural support systems; family & community support, assistance, & education; protection & advocacy; & service coordination. Services provided by organizational staff or through linkages with other resources & provided in the individual's home or other natural community environment where the skills are learned or used. Service is not part of an organized mental health support or treatment group, drop-in center, or clubhouse. Skill training groups may be one of the activities in the service plan & part of supported community living. Skill training groups cannot stand alone as a supported community living service. Higher intensity services require more frequent contacts with the client & psychiatrist than do lower intensity services. No prior authorization required for lower intensity services.
H0035 **S9125**	**Respite**	
	Service Description	Brief intervention that may be provided in home or community settings. May be planned or provided in response to crisis or risk of crisis. Includes provider training/qualifications, documentation, coordination requirements.
H0038	**Peer Support**	
	Service Description	Recovery oriented services. Support, education, & other activities provided by trained peer specialists for adults with SPMI &/or substance abuse disorders. Includes minimum number & frequency of contacts, caseload size, treatment planning & supervision requirements.
Q3014	**Telehealth**	
	Service Description	Care/service coordination provided by an RN for members receiving psychiatric services via telehealth. Includes member/family education, coordination with other providers, follow-up & documentation requirements. Members must meet criteria for outpatient services.
99510	**Mobile Counseling**	
	Service Description	Therapy services provided in member's home or community for members who cannot access office-based out-patient services. Includes provider qualifications, documentation, & discharge

Code	Service/Requirements	Iowa
		planning requirements. May be used for maintenance.
T2022	**Case Management**	
	Diagnostic Criteria	SPMI
	Eligibility & Other Service Requirements	18 years of age or over & has a persistent mental or emotional disorder that seriously impairs the person's functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. Typically meet at least one of the following criteria: • Psychiatric TX more intensive than outpatient care more than once in a lifetime. • At least 1 episode of continuous, structured, supportive residential care other than hospitalization. Typically meet at least 2 of the following criteria on a continuing or intermittent basis for at least 2 years: • Unemployed, or employed in a sheltered setting, or have markedly limited skills & a poor work history. • Financial assistance required for out-of-hospital maintenance & may be unable to procure this assistance without help. • Severe inability to establish or maintain a personal social support system. • Help in basic living skills required. • Inappropriate social behavior which results in demand for intervention by the mental health or judicial system. <u>Services:</u> • Intake, which includes ensuring that there is sufficient information to identify all areas of need for services & appropriate living arrangements. • Assurance that a service plan is developed which addresses consumer's total needs for services & living arrangements. • Assistance to the consumer in obtaining services & living arrangements identified in service plan. • Coordination & facilitation of decision-making among providers to ensure consistency in implementation of service plan. • Monitoring services & living arrangements to ensure their continued appropriateness. • Crisis assistance to facilitate referral to appropriate providers for resolution. • Discharge planning activities for institutionalized persons for a period not to exceed 30 days prior to discharge date & for discharge activities which do not duplicate discharge planning activities of the institution. At a minimum, contact with or on behalf of a client must occur once/month. This may include activities such as telephone calls to a provider or to the client's legal representative, visits by the case manager to a service provider, or conferences with members of the interdisciplinary team. Face-to-face contact with the client must occur at a minimum quarterly. Case management services

Code	Service/Requirements	Iowa
		are the responsibility of a specific case manager whose primary responsibility to the client is case management. Case management is provided for a period of time & at a level of intensity determined by the individual client's needs.
	Coordination of Care Requirements	Coordination with other service providers & community agencies/resources
	Authorization/Review Frequency	At time of initial assessment & at least annually
	Documentation Requirements	Case management file including service plan, evidence of need for case manager to manage multiple resources pertaining to medical & interrelated social & education services for benefit of the consumer
H2022	**Integrated Mental Health Services & Supports**	
	Service Description	Non-traditional wrap around services/activities/supports approved as part of the TX plan directly related to specific goals & objectives. Examples include instruction, transportation, coaching.

Appendix 5—UM Guidelines for Texas

Code	Service/Requirements	Texas NorthSTAR
H2011	**Mobile Crisis**	
	Diagnostic Criteria	N/A
	Admission, Continued Stay, & Other Service Criteria	Admission: The consumer, family member, emergency room staff, law enforcement agencies, social service/mental health agencies or providers must request this LOC. **and** 1 of the following: Consumer is in an active state of crisis Suicidal/assaultive/destructive ideas, threats, plans, or attempts as evidenced by degree of intent, lethality of plan, means, hopelessness, or impulsivity; or acute behavioral, cognitive, or affective loss of control that could result in danger to self or others Significant incapacitating or debilitating disturbance in mood/thought that is disruptive to interpersonal, familial, or occupational functioning to the extent that immediate intervention is required; **or** Intervention must be reasonably expected to improve the individual's condition or resolve the crisis. Continued Stay: N/A Other: Clinically staffed mobile TX units that provide face-to-face emergency evaluation & services when a consumer in crisis cannot be served at a hospital or clinic setting. Designed to reach individuals at home, school &/or other community based locations, 24 hrs/day, 365 days/yr. May be individual or team delivered by mental health professionals or crisis workers. Includes crisis intervention, assessment, counseling, resolutions, referral & follow-up.
	Coordination of Care Requirements	Back up & linkages with other services & referrals
	Authorization/Review Frequency	Up to 3 units with no prior authorization required
	Documentation Requirements	Not specified
154	**Hospital-Based Crisis Stabilization**	
	Diagnostic Criteria	Symptoms consistent with a DSM-IV-TR (Axis III) DX
	Admission, Continued Stay, & Other Service Criteria	Presenting crisis & cannot be safely evaluated & managed in a less intense LOC. Indications that symptoms may be stabilized in this environment & alternative TX be initiated. **and** at least 1 of the following: Actual or potential danger to self as evidenced by serious suicidal intent or recent attempt with continued intent. Command hallucinations or delusions leading to suicidal or homicidal intent. Actual or potential danger to others as a result of psychiatric illness. Loss of impulse control leading to life-threatening behavior &/or

Code	Service/Requirements	Texas NorthSTAR
		other psychiatric symptoms requiring immediate stabilization in a structured, psychiatrically monitored setting. Substance intoxication with suicidal/homicidal ideation. Crisis demonstrated by an abrupt or substantial change in normal life functioning brought on by a specific cause, sudden event, &/or severe stressor. **or** Significant incapacitating or debilitating disturbance in mood &/or thought interfering with ADLs to the extent that immediate stabilization is required. <u>Continued stay:</u> N/A Other: Intensive crisis intervention in a secure, protected, clinically staffed, psychiatrically supervised TX setting. Designed to provide a safe, secure environment for short-term stabilization of symptoms. Includes comprehensive assessment & preliminary TX plan to stabilize the individual & discharge to an appropriate LOC.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required. Typical length of stay: 1-3 days
	Documentation Requirements	Not specified
154	**Community-Based Crisis Stabilization**	
	Diagnostic Criteria	Active symptoms consistent with a DSM-IV-TR (Axis I/II) DX
	Admission, Continued Stay, & Other Service Criteria	<u>Admission:</u> Based on psychiatric evaluation the individual: Does not have symptoms due solely to a substance abuse disorder Has symptoms requiring intensive structured intervention Is experiencing dramatic & sudden decompensation, with a strong potential for danger to self &/or others, & has no family/significant others to provide continuous monitoring Can be effectively treated with short-term intensive stabilization services & returned to a less intensive LOC within a brief time frame. **and** Is experiencing the onset of a life-endangering psychiatric condition, with inadequate information to determine the appropriate LOC. <u>Continued stay:</u> Clinically appropriate TX focused on outcomes defined in the discharge/transition plan TX planning is individualized, realistic, & appropriate to the individual, with specific goals & objectives Services are structured to achieve maximum results in the most timely way possible Condition continues to meet admission criteria at this LOC & a less intensive LOC would be inadequate Documented evidence of efforts to establish a realistic discharge plan to transition the individual to a less intensive LOC **and** Individual demonstrates ability to benefit from the evaluation & TX provided. <u>Other:</u> Services available 24 hrs/365 days/yr. & provide an alternative to

Code	Service/Requirements	Texas NorthSTAR
		hospitalization that provides short-term psychiatric TX in structured community based therapeutic settings. Provides continuous 24-hr. observation & supervision to consumers who do not require the intensive medical or psychiatric care of a hospital & would benefit from a short-term, structured stabilization setting. Services include crisis stabilization, evaluation, care management, medication management, & mobilization of family support & community resources. Designed to facilitate the return of the individual to the community as rapidly as possible while generating support necessary to maintain optimum level of functioning.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required. Typical length of stay: 1- 3 days.
	Documentation Requirements	Not specified
762	**23 Hour Observation & Treatment**	
	Diagnostic Criteria	Symptoms consistent with a DSM-IV-TR (Axis I-II) DX
	Admission, Continued Stay, & Other Service Criteria	Likely to respond to therapeutic intervention. Indications that symptoms may stabilize & alternative TX may be initiated within 23 hrs. Presenting crisis cannot be safely evaluated or managed in a less restrictive setting. **and** at least 1 of the following: Indication of actual or potential danger to self Command auditory/visual hallucinations or delusions leading to suicidal or homicidal intent. Indication of actual or potential danger to others as a result of a psychiatric illness. Loss of impulse control leading to life-threatening behavior &/or other psychiatric symptoms requiring immediate stabilization in a structured psychiatrically monitored setting. Substance intoxication with suicidal/homicidal ideation. Abrupt or substantial change in normal life functioning brought on by a specific cause, sudden event, &/or severe stressor. Significant incapacitating or debilitating disturbance in mood &/or thought interfering with ADLs to the extent that immediate stabilization is required. <u>Continued stay:</u> N/A <u>Other:</u> Observation/holding beds in a secure & protected, clinically staffed, psychiatrically supervised TX setting designed to provide a safe, secure environment for short-term stabilization. Includes comprehensive assessment & TX plan to stabilize the individual & discharge to an alternate LOC.
	Coordination of Care Requirements	TX team coordinates support linkages.
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
H0018	**Intensive Crisis Residential**	

Code	Service/Requirements	Texas NorthSTAR
	Diagnostic Criteria	Active symptomatology consistent with DSM IV-TR Axis I-II DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Significant incapacitating or debilitating disturbance in mood/thought interfering with ADLs to the extent that immediate stabilization is required **and** Consumer requires & can reasonably be expected to respond to intensive, structured intervention **and** Clinical evaluation indicates dramatic & sudden decompensation with strong potential for danger (but not imminent danger) to self or others & consumer has no available supports to provide continuous monitoring **and** 24 hr. observation & supervision required but not the constant observation of an inpatient psychiatric setting **and** Clinical evaluation indicates that the consumer can be effectively treated with short-term intensive crisis intervention services & returned to a less intensive LOC within a brief time frame **and** A less intensive or restrictive LOC has been considered or tried **or** Clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is inadequate information to determine the appropriate LOC. Continued stay: Consumer's (&/or the family) situation &/or lack of functioning has yet to be resolved. Does not require a more intensive LOC & no less intensive LOC would be appropriate. Care is rendered in a clinically appropriate manner focused on behavioral & functional outcomes as described in the discharge plan TX planning is individualized & appropriate to consumer's status with realistic, specific goals & objectives stated. Services are structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Progress in relation to specific symptoms or impairments is clearly evident & can be described in objective terms, but TX goals have not been reached or adjustments in TX plan to address lack of progress are evident. When medically necessary, appropriate psychopharmacological intervention has been prescribed &/or evaluated. **and** Documented active discharge planning. Other: 24-hour supervised, community based, short-term TX model serves as an alternative to inpatient hospitalization. Consumers in urgent/emergency need receive crisis stabilization services in a safe, structured setting, with continuous 24-hr. observation & supervision. Services include crisis stabilization, initial & continuing assessment, care management, medication management, &m mobilization of family support & community resources. Primary objective is to promptly conduct a comprehensive assessment & develop a TX plan focused on crisis intervention services necessary to stabilize & restore the consumer to a level of functioning which requires a less restrictive LOC.
	Coordination of Care Requirements	Facilitation of appropriate linkages coordinated by TX team
	Authorization/Review Frequency	Prior authorization required. Typical length of stay: 1-14 days

Code	Service/Requirements	Texas NorthSTAR
	Documentation Requirements	Not specified
T1023	**Personal Care Homes/Assisted Living**	
	Diagnostic Criteria	Bipolar Disorder, Schizophrenia, or related disorder
	Admission, Continued Stay, & Other Service Criteria	Admission: Consumer can reasonably be expected to respond to therapeutic intervention. Consumer is not sufficiently stable to be treated outside of a supervised setting. Consumer demonstrates capacity to respond favorably to assistance in areas such as problem solving, life skills development, & medication self-management training such that reintegration into the family unit or a foster home is a realistic goal. **and** Consumer is able to function with some independence & participate in community-based activities for limited periods of time (e.g., employment, drop-in centers) Continued stay: Continues to meet admission criteria Does not require a more intensive LOC & no less intensive LOC would be appropriate. TX planning is individualized & appropriate to the consumer's changing status, with realistic & specific goals & objectives Services are structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Progress in relation to specific symptoms or impairments is clearly evident & can be described in objective terms, but TX goals have not yet been achieved or adjustments in TX plan to address lack of progress are evident. Services are clinically appropriate & focused on the consumer's behavioral & functional outcomes described in the discharge plan. When appropriate, family involvement is incorporated into the TX/discharge plan. When medically necessary, appropriate psychopharmacological intervention has been prescribed &/or evaluated. **and** Documented active discharge planning. Other: Establishments, including board & care homes, licensed by the state that provides food & shelter to 4 or more persons who are unrelated to the proprietor & that provide personal care services such as assistance with meals, dressing, movement, bathing, or other personal needs & maintenance. Services include assistance with or supervision of medication by a person licensed to administer medication or general oversight of the physical & mental well-being of a person who needs assistance to manage personal life.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required
	Documentation Requirements	Not specified
H0035	**Partial Hospital**	
	Diagnostic Criteria	Axis I or II DSM IV DX

Code	Service/Requirements	Texas NorthSTAR
	Admission, Continued Stay, & Other Service Criteria	Admission: Need for TX of psychiatric disorder Ample social support system to provide the necessary stability **or** Risk to self/others/property does not require 24-hr. medical supervision. At least 1 of the following: Suicidal ideation or non-intentional threats or gestures Recent history of self-mutilating, risk-taking, or other self-endangering behavior Destructive behavior toward property Disordered or bizarre behavior, psychomotor agitation, or retardation interferes with ADLs to the extent that psychiatric structure & supervision are required for a significant part of the day Mood or thought disorder interferes with ability to fully resume family, or school responsibilities unless psychiatric/social/vocational rehabilitation services are provided Side effects of atypical complexity resulting from psychotropic drugs **or** Severe, sustained, pervasive inability to attend to age appropriate responsibilities &/or severe deterioration of functioning requiring structured psychiatric programming. Continued stay: Routine medical observation & supervision required for significant regulation of psychotropic & other medication Active structured TX & behavioral interventions needed to maximize functioning or minimize risks to self/others/property Routine medical observation & supervision needed to minimize serious side effects of medication or maximize medical management of co-existing medical conditions **or** Comprehensive, multi-modal TX plan required because TX plan formulated during inpatient hospitalization has enabled the individual to function without continuous observation & supervision, but not at a lower LOC. Other: Therapeutically intensive acute short term TX in a stable therapeutic environment for comprehensive assessment, DX, & TX of severe emotional &/or behavioral disabilities. Available for a minimum of 6 hrs./day, 5 days/wk with afternoon & evening hours. Goal is to increase level of functioning. May be used as diversion from acute inpatient treatment or shorten the length of stay or enhance crisis stabilization or support transition back to the community. Staff-consumer ratio must be sufficient to ensure therapeutic services & professional monitoring.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
G0177	**Day Treatment Acute**	
	Diagnostic Criteria	Axis I DSM-IV-TR DX of Schizophrenia, Schizophrenia related disorders, Bipolar Disorder, or Major Depressive Disorder with Psychotic Features
	Admission, Continued Stay,	Admission:

Code	Service/Requirements	Texas NorthSTAR
	& Other Service Criteria	18 years old or older TX of a psychiatric disorder &/or co-occurring substance abuse requiring a structured milieu based treatment setting; Suicidal ideation without imminent threat &/or chronic non-intentional threats or gestures requiring 24-hr. monitoring Recent &/or chronic history of self-mutilating, risk-taking, or other self-endangering behavior Assaultive &/or threatening tendencies exist that do not require 24-hr. protected, controlled, or monitored environment **or** Destructive behavior toward property, & evidence of ability to reliably attend the program <u>Continued stay:</u> Development of an individualized, goal-directed TX plan Participation by the consumer at least 2 days/wk. with services including: • Individual, group, family, & other therapy • Therapeutic recreation & structured leisure time activities; • Assistance with developing skills to maintain ADLs • Crisis intervention • Supervision of self-administration of medication & • Development of a rehabilitation plan with self-determined goals **and** Providers ensure that the consumer has: • Opportunities for involvement in community, social, athletic, & recreational programs • Opportunities to pursue personal, ethnic, & cultural interests.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
H0047	**Intensive Outpatient**	
	Diagnostic Criteria	Symptomatology consistent with an Axis I DSM-IV-TR DX of Schizophrenia, Schizophrenia related disorder, Bipolar Disorder, or Major Depressive Disorder with Psychotic Features
	Admission, Continued Stay, & Other Service Requirements	<u>Admission:</u> Requires & can reasonably be expected to respond to therapeutic intervention Expectation that the consumer will show significant progress toward TX goals within the specified time frames as dictated by the focus of the program. Significant symptoms that interfere with the ability to function in at least 1 life area. **or** Complex family dysfunction interferes with the ability to benefit from traditional outpatient TX without family involvement. **or** Noncompliance makes outpatient psychotherapy management impossible without team interventions & structure. Requires a coordinated, office-based TX plan that may require different modalities &/or clinical disciplines for progress to occur. <u>Continued stay:</u> Continues to meet admission criteria

Code	Service/Requirements	Texas NorthSTAR
		Does not require a more intensive LOC & no less intensive LOC would be appropriate. TX plan is individualized, appropriate to individual's status, with realistic, specific goals & objectives Services are structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Progress in relation to specific symptoms or impairments is clearly evident & can be described in objective terms, but TX goals have not been reached or changes in TX plan to address lack of progress are evident. Clinically appropriate TX focused on individual's behavioral & functional outcomes as described in discharge plan. Consumer actively participates in continued TX as evidenced by compliance with program rules/procedures. When medically necessary, psychopharmacological intervention is prescribed &/or evaluated. **and** Documented active discharge planning. <u>Other:</u> Time limited, multidisciplinary, multi-modal structured TX in an outpatient setting, typically 3 hrs/day, 2 to 4 times/wk. for brief episodes of care. Less intensive than partial hospital or day TX but significantly more intensive than outpatient psychotherapy & medication management. Interventions include individual, couple & family psychotherapy, group therapies, medication management, & psycho-educational services. Adjunctive therapies such as life planning skills (assistance with vocational, educational, financial issues) & special issue or expressive therapies, (included in the per diem), may be provided but must have a specific function within a given patient's TX plan. As functioning improves, TX hrs. decrease. TX plans must be individualized & focus on acute stabilization & transition to community outpatient TX & support groups as needed.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
H2017	**Psychosocial Rehabilitation**	
	Diagnostic Criteria	Most recent principal DX: Schizophrenia & Related Disorders or Bipolar Disorder or Major Depressive Disorder with psychotic features
	Admission, continued Stay, & Other Service Criteria	<u>Admission:</u> Member is 18 or over Demonstrates medical necessity according to the Texas Recommended Assessment Guidelines (TRAG) with specific ratings in the following dimensions:. • Risk of Harm • Support Needs • Psychiatric-Related Hospitalizations • Functional Impairment • Employment Problems • Housing Instability • Co-Occurring Substance Use

Code	Service/Requirements	Texas NorthSTAR
		• Criminal Justice Involvement Continued stay: Symptoms continue to indicate the need for these services as demonstrated by continued qualification based on TRAG scores. Must be participation by the consumer & the family Other: Social, educational, vocational, behavioral, & cognitive interventions that address deficits in the individual's ability to develop & maintain social relationships, occupational or educational achievement, & independent living skills that are the result of an SPMI. May also address the impact of co-occurring disorders on the ability to reduce symptomology & increase functioning. Services: independent living services, case management, coordination of services, employment related services, housing related services, & medication related services. Part of a team approach to community mental health services. Persons are provided pharmacological management, medication training & supports & assigned a rehabilitative case manager whose low caseload allows them to provide psychosocial rehabilitation through extensive linking, advocating, & focused course of individual & small group skills training & development, supported employment, & co-occurring substance use services.
	Coordination of Care Requirements	Service coordination
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
H2014	**Skills Training & Development**	
	Diagnostic Criteria	Most Recent Principal DX: Schizophrenia & Related Disorders or Bipolar Disorder or Major Depressive Disorder
	Admission, Continued Stay, & Other Service Requirements	Demonstrates medical necessity according to TRAG ratings in the following dimensions:. • Risk of Harm • Psychiatric-Related Hospitalizations • Functional Impairment • Response to Medication Treatment Continued stay: Symptoms continue to indicate the need for these services as demonstrated by continued qualification based on TRAG scores. Must be participation by the consumer & the family Other: Services address SPMI & symptom-related problems that interfere with the individual's functioning & living, working, & learning environment; provides opportunities to acquire & improve skills needed to function as appropriately & independently as possible in the community. Facilitates community integration & increases community tenure. Includes teaching an individual the following skills: skills for managing daily responsibilities (e.g., paying bills, attending school, performing chores); communication skills (e.g., effective communication & recognizing or changing problematic communication styles); pro-

Code	Service/Requirements	Texas NorthSTAR
		social skills (e.g., replacing problematic behaviors with socially acceptable behaviors); problem-solving skills; assertiveness skills; social skills: stress reduction (e.g., progressive muscle relaxation, deep breathing exercises, guided imagery, & selected visualization); anger management skills (e.g., identification of antecedents to anger, calming down, stopping & thinking before acting, handling criticism, avoiding & disengaging from explosive situations); skills to manage symptoms of mental illness & recognize & modify unreasonable beliefs, thoughts, & expectations; skills to identify & use community resources & informal supports; skills to identify & use acceptable leisure time activities (e.g., identifying pleasurable leisure time activities that foster acceptable behavior); & independent living skills (e.g., money management, accessing & using transportation, grocery shopping, maintaining housing, maintaining a job, & decision making).
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
H0034	**Medication Training & Support Services**	
	Diagnostic Criteria	SPMI
	Admission, Continued Stay, & Other Service Requirements	Admission: Must meet TRAG criteria for ongoing out-patient services Must be a new start to psychiatric medications or have a history of noncompliance documented over the last 6 months of TX. Continued stay: Symptoms must continue to indicate the need for these services as demonstrated by continued qualification based on TRAG scores. Must be participation by the consumer & the family Other: Training to assist an individual in: understanding the nature of SPMI; understanding the role of prescribed medications in reducing symptoms & increasing or maintaining functioning; identifying & managing symptoms & potential side-effects of the medication; learning contraindications of the medication; understanding overdose precautions of the medication; & learning medications self-administration.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Non-compliance history
H0040	**Assertive Community Treatment**	
	Diagnostic Criteria	Behavior consistent with a DSM-IV-TR DX of Bipolar disorder or Schizophrenia related disorders
	Admission Continued Stay, & Other Service Criteria	Admission: Has required periodic hospitalization as indicated by a moderate, significant, or high rating on TRAG **and** Individual does not have adequate family support & needs external

Code	Service/Requirements	Texas NorthSTAR
		ADL & social support to remain stable outside of an inpatient environment, or to transition to independent living from a more restrictive setting **and** Lack of therapeutic response to rehabilitation services demonstrated by an inability to sustain involvement with needed services, or evidence that a comprehensive integrated program of medical & psychosocial rehabilitation services is needed to support improved functioning at the least restrictive LOC. <u>Continued stay:</u> Severity of illness & resulting impairment continues to require this level of service; Services focus on reintegration into the community & improving functioning in to reduce unnecessary utilization of more intensive TX alternatives Mode, intensity, & frequency of TX is appropriate Active TX is occurring & continued progress toward goals is anticipated TX planning is individualized & appropriate to the individual's status & includes the following as appropriate to stabilize & improve functioning: • Outreach (e.g., linkage with community agencies, educational presentations); • Assistance & referral with meeting basic needs (e.g., housing, food, medical care) • Psychosocial evaluation & TX • Crisis intervention • Social rehabilitation • Consumer & family support & education (e.g., symptom management) • Coordination & development of alternative support systems (e.g., religious organizations, self-help groups, peer support) • Protection & advocacy resources • Coordination of services, including vocational, medical, & educational needs • Medication & TX monitoring. Services provided as needed & agreed upon in the TX plan by providers & individual. **and** Continued services required to maximize functioning & sustain recovery or individual's support network (e.g., family, friends, & peers) is insufficient to allow for independent living. <u>Other:</u> Provides an array of services delivered by a community based, mobile, multidisciplinary team of professionals & paraprofessionals to individuals with long-standing psychiatric illnesses or substance abuse disorders who have experienced previous hospitalizations or episodes of impairment that have placed the individual at risk of hospitalization. Designed to be maximally flexible in supporting individuals who have a demonstrated inability to independently access & sustain involvement with needed services due to history of noncompliance &/or functional limitations. Assists in developing competencies needed to achieve recovery, function as independently as possible, & sustain a support network. Services, provided in the individual's primary language, are designed to meet

Code	Service/Requirements	Texas NorthSTAR
		the unique needs of the individual, based on his/her cultural values and norms. May be provided at agency-based psychiatric rehabilitation programs (e.g., clubhouse model, other community-based psychosocial program) or in community settings (e.g., home, job site, or homeless shelter). Include assistances with addressing basic needs (e.g., food, housing, medical care), & comprehensive integrated program of psychosocial rehabilitation services to support improved social, educational, & vocational functioning. Individuals living in supported living situations (excluding supported housing) may receive ACT services if the objective is to prevent the need for placement in a more restrictive setting. Also provides mental health services to individuals who are homeless or in imminent risk of becoming homeless. The program has an outreach component geared towards assessment & linkage to appropriate treatment and community services. Services provided predominantly through face to face individual services. The multidisciplinary make-up of each team & the small consumer-to-staff ratio, allows the team to provide most services with minimal referrals to other mental health programs or providers. The ACT Fidelity Instrument requires that 80% or greater of all direct services are delivered out of the office. A combination of office & community based group services should never exceed 40% of the total care delivered each month.
	Coordination of Care Requirements	Service coordination, linkage with treatment & community resources
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
T1017	**Routine Case Management**	
	Diagnostic Criteria	Schizophrenia, bipolar disorder, or major depression
	Admission, Continued Stay, & Other Service Criteria	<u>Admission:</u> Clinical need for the service as evidenced by TRAG Assessment Scores with service intensity need reflected by higher TRAG score in the following dimensions: • Risk of Harm • Support Needs • Psychiatric-Related Hospitalizations • Functional Impairment • Employment Problems • Housing Instability • Co-Occurring Substance Use • Criminal Justice Involvement <u>Continued stay:</u> Continues to meet admission criteria Progress documented toward the goals established **and** Continued inability to obtain or coordinate services without program support. <u>Other:</u> Activities that are provided to assist adults with SPMI in gaining access to resources & services. Proves support & assistance to the person in achieving defined personal goals. This service is provided by a qualified mental health professional face to face with the

Code	Service/Requirements	Texas NorthSTAR
		consumer. Services assist an individual in gaining & coordinating access to necessary care & services appropriate to the individual's needs. Includes face-to-face meetings with the individual, or primary caregiver at the case manager's work site to identify the needs of the individual & assist the individual in gaining access to a community resource that may address those needs.
	Coordination of Care Requirements	Coordination of services with the individual & family, & emergency services to respond to a crisis as needed.
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
H2023	**Supported Employment**	
	Diagnostic Criteria	Mental illness
	Admission, Continued Stay, & Other Service Criteria	Admission: At least 18 years old. Consumer exhibits symptoms such that s/he needs assistance in choosing & obtaining employment as demonstrated by TRAG score on following dimension: Employment Problems. Continued stay: Symptoms & TRAG scores must continue to indicate the need for these services **and** Must be participation by the consumer & the family Other: Provides individualized assistance in choosing & obtaining employment at integrated work sites in jobs in the community of consumer's choice. Supports are provided by staff who assist the individual in keeping employment &/or finding another job as necessary.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
S5140	**Adult Foster Care**	
	Diagnostic Criteria	SPMI
	Admission, continued Stay, & Other Service Criteria	Admission: Psychiatric symptoms which require & can reasonably be expected to respond to therapeutic intervention. Must currently be receiving behavioral health services use of this LOC in part of a comprehensive TX plan. Continued stay: N/A Other: Long-term placement for adults with SPMI designed to provide a safe, secure & stable home environment in which the consumer can experience normalizing activities & relationships.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified

Code	Service/Requirements	Texas NorthSTAR
90801	**Diagnostic Interview/Assessment**	
	Diagnostic Criteria	N/A
	Admission, Continued Stay, & Other Service Criteria	Diagnostic evaluations are used to collect sufficient clinical data to determine the presence of a DSM-IV- TR DX &/or need for services required for the optimum functioning of the individual. At a minimum, this evaluation should consist of obtaining information from the individual, family &/or support system, & other medical, psychiatric or social history as available. This information should: • Establish the level of function • Establish a psychiatric DX, if present • Identify psychosocial & medical needs • Define strength/availability of support system **and** • Provide enough data for development of TX alternatives & recommendations. For current recipients of services, diagnostic evaluation is indicated when the individual's level of function undergoes an acute change. For those who have never had a diagnostic evaluation, indications that one may be needed include active psychiatric symptoms; self-destructive behavior; or acute changes in behavior not explained by other circumstances but which suggest an underlying psychiatric or social cause. Repeat hospitalizations, work/school failure or poor performance, social withdrawal, suicide attempts, &/or difficulty in maintaining relationships may be a result of a psychiatric disorder or may reflect turmoil in the family or support setting. If an evaluation has been completed in last 30 days there is no need for a repeat evaluation unless symptoms or level of function have changed.
	Coordination of Care Requirements	With consent from the individual evaluation is communicated to referral source & members of TX team.
	Authorization/Review Frequency	Up to 3 units with no prior authorization
	Documentation Requirements	Review of presenting problem(s) or symptoms; description of risk level including specific examples of threats, plans, actions; thorough mental status exam; level of function, GAF score, or other standard score or description; psychiatric, social, & medical history; list of current TX modalities, including medication; description of family/developmental history; DX (DSM-IV-TR, Axes I-V); & recommended TX plan, including specific goals, discharge plan, & projected length of time or number of visits required, taking both clinical & psychosocial issues into account.
90847	**Family Therapy**	
	Diagnostic Criteria	N/A
	Admission, continued Stay, & Other Service Criteria	<u>Admission:</u> Any of the following: Individual's symptoms result from family stressors or dynamics &are expected to be reduced as a result of family therapy LOC needed to integrate the individual's TX goals into the family unit Adult consumer has given consent for family or support system to participate in TX Family/interpersonal relationships are identified as problematic Family dynamics are a significant precipitant of symptoms &/or stabilization of family dynamics is instrumental to the consumer's

Code	Service/Requirements	Texas NorthSTAR
		return to the community **or** Family is helped to prepare for the return of a family member after an acute LOC & is significant support for the individual. <u>Continued stay:</u> Individual & family are appropriately participating; **and** A jointly developed TX plan, including the consumer & family members, is documented to address: • Family strengths • Family issues to be resolved • Specific intervention to be used & • Length of TX. <u>Other:</u> Conducted with the consumer & key family members to reduce symptomatology & integrate the individual's TX goals into the family unit. May also be used to help families cope with the stressors of having a family member with severe mental illness. Key components include assisting family members with the identification of problems in relationships within the family, identifying & maximizing their strengths, & developing problem-solving techniques.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Up to 3 units with no prior authorization,
	Documentation requirements	TX plan
	Group Therapy	
90853	**Diagnostic Criteria**	Clearly identified problem or symptoms resulting from a DSM-IV-TR, Axis I diagnosis of Major Depression
	Admission, continued Stay, & Other Service Criteria	<u>Admission:</u> Member has been assessed in need of therapy services as indicated on the Texas Implementation of Medication Algorithms (TIMA) protocol for adults with Major Depression Disorder **and** Group therapy is preceded by an initial face-to-face assessment to determine the appropriateness of the group, & to provide education on group structure, process, & expectations. Some individuals may require preparation for group therapy beyond the initial assessment. This may involve a course of 3-5 individual sessions to clarify the purpose of group therapy & address issues the individual raises. Individuals not receptive to group therapy after this preparation may be directed to individual therapy. Individual is motivated for change or is likely to become engaged in this TX Cognitive abilities are intact, s/he can assume responsibility for behavioral change, & is capable of developing coping skills for long-term problem solving. <u>Continued stay:</u> Group is led by a trained therapist, using specific techniques & theoretical constructs; Open groups are structured to accommodate new group members. closed group models may be preferable when the group process & interpersonal roles & relationships are the focus. **and** Multiple TX modalities for the same problem or DX (e.g., individual & group psychotherapy) must be considered in the

Code	Service/Requirements	Texas NorthSTAR
		context of a comprehensive TX plan. Other: Participants utilize interactions with others, develop improved social skills and their needs are met through acceptance, mutual support, help in overcoming maladaptive behavioral patterns, & facilitation of undistorted self-disclosure facilitated in the group process. Emphasizes understanding & change of behavioral patterns through opportunities for feedback & experience unavailable through individual TX. Typically consists of weekly meetings of between 4 & 12 participants, & 1 -2 hr. sessions.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Up to 3 units with no prior authorization
	Documentation Requirements	All sessions, TX plans, & interventions are documented
90862	**Medication Management**	
	Diagnostic criteria	Schizophrenia or related disorders, bipolar disorder, major depression with psychotic features
	Admission, Continued Stay, & Other Service Criteria	Admission: A problem has been identified which is expected to respond to medication; **and** Evaluation needed for medication use, obtain a prescription, or (for those currently taking psychotropic medication/s) be medically monitored. Continued stay: Medication or other medical service is prescribed by a qualified physician, preferably a psychiatrist (non-psychiatrist where psychiatrist is not available, such as in rural areas) Physician meets face-to-face with the consumer, on a scheduled basis as clinically necessary Physician collaborates with the psychotherapist or TX team, & PCP when the prescription is renewed or changed. Other: Classified into 1 of 2 categories: 1) providing medical supervision & prescribing or evaluating the need for psychotropic drugs to an individual in TX with a non-medical psychotherapist; or 2) providing medical services, including prescription of psychotropic drugs, to an individual not currently in need of psychotherapy. May be provided by a licensed nurse under the supervision of a physician in monitoring dosage, side effects & effects of the medication, compliance, weight, nutritional status, vital signs, collection of blood & urine samples & monitoring health status. An advanced clinical nurse practitioner additionally may diagnose, prescribe & formulate a TX plan. May be provided by a physician assistant, under the supervision of a physician, who can monitor side effects, drug dosage & effectiveness of medications & actively prescribe. Medication management groups provide additional support & improve participation & therapeutic benefit for selected individuals. The group (in addition to administering prescriptions or injections) must involve: group discussion & education on illness & mutual support.
	Coordination of Care	Collaboration with psychotherapist or TX & PCP when the

Code	Service/Requirements	Texas NorthSTAR
	Requirements	prescription is renewed or changed.
	Authorization/Review Frequency	No authorization required
	Documentation Requirements	Not specified
Standard CPT codes	**Walk-in Crisis Assessment**	
	Diagnostic Criteria	None
	Admission, Continued Stay, & Other Service Criteria	Admission: Service available to anyone who feels that they are in crisis as a result of an acute problem of disturbed thought, behavior, mood or social relationship. Continued stay: None Other: Services intended to provide rapid screening & early intervention to consumers &/or their families experiencing acute psychiatric symptoms & distress. Primary goal is immediate assessment & interventions designed to stabilize acute symptoms of psychiatric illness &/or emotional distress. Services accessible & available 24 hrs/day, 365 days/yr. Provided at provider site in face-to-face contact with individuals in crisis or with individuals seeking help for persons in crisis. Available at licensed facility or by qualified mental health professional. Includes assessment, information & referral, crisis counseling, crisis resolution, accessing community resources & backup, & psychiatric or medical consultation. Provides intake, documentation, evaluation and follow-up.
	Coordination of Care Requirements	Coordination with community resources, back up & consultation
	Authorization/Review Frequency	No authorization required
	Documentation Requirements	Not specified
Standard CPT codes	**Home-Based Behavioral Health Treatment**	
	Diagnostic Criteria	Mental illness or co-occurring mental & physical illness
	Admission, Continued Stay, & Other Service Criteria	Admission: The individual must have a diagnosis of a mental illness or be at risk from co-occurring physical & mental illnesses or be prescribed psychotropic medications, or have potential for admission to a psychiatric inpatient setting due to risk management factors. Continued Stay: The facility or support system must allow for the participation of the nurse in the TX planning process, & at least 1 of the following: The consumer or caretaker/guardian demonstrates a continued limited ability to ensure the safety of the consumer with respect to medication management & health issues (medical/mental health). Nursing care is required to preserve community tenure. Other: Psychiatric intervention & TX to assess & stabilize symptomatology, & maintain & /or improve level of functioning to prevent inpatient hospitalization &/or long term care placement.

Code	Service/Requirements	Texas NorthSTAR
		Includes crisis intervention, individual, group or family therapy, & medication as clinically appropriate.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Not specified
96101 96118	**Psychological & Neuropsychological Testing**	
	Diagnostic Criteria	Schizophrenia or other related disorders, bipolar disorder, or major depression with psychotic features
	Admission, Continued Stay, & Other service Criteria	Admission: Consumer is an adult with schizophrenia or other related disorders, bipolar disorder, or major depression with psychotic features **and** Significant uncertainty concerning the appropriate course of TX for an individual who, for no clear reason, has not responded to standard TX. In these cases, psychological testing results may be used to modify the TX plan. Psychological testing should not be routinely administered as an approach to evaluation or administered based on a facility's requirement but, rather, be conducted based on the individual's clinical circumstances **or** Testing is needed for a differential DX when traditional assessment procedures fail to clarify DX. **and** Clinical indications for testing & testing to resolve the same questions has not been administered within the last yr. &/or there is strong evidence that new events have significantly affected the individual's functioning **and** Testing is not primarily for educational purposes **and** All procedures conducted as part of psychological testing, including but not limited to the administration, scoring, interpretation, & written report of findings, must be conducted by or under supervision of a licensed clinical psychologist **and** When administration of psychological or neuropsychological testing is delegated to a psychological assistant/psychometrician, the report must be reviewed & signed by the supervising psychologist or neuropsychologist responsible for its contents.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required.
	Documentation Requirements	Written report of findings
S9125	**Respite**	
	Diagnostic Criteria	Symptoms consistent with a DSM IV AXIS I-II DX
	Admission, Continued Stay, & Other Service Criteria	Admission: Symptoms require & can reasonably be expected to respond to therapeutic intervention. Must currently be receiving behavioral health services & use of this LOC in part of a comprehensive TX plan. **and** Caregiver has requested this level of care due to a planned event or an immediate need. Continued stay:

Code	Service/Requirements	Texas NorthSTAR
		None Other: Designed to relieve caregiver stress & provide the consumer with opportunities for different social milieu. Respite care can be provided in or out of the home in a variety of settings and may be planned/scheduled in advance or arranged for on an emergency basis.
	Coordination of Care Requirements	Not specified
	Authorization/Review Frequency	Prior authorization required
	Documentation Requirements	Not specified

Appendix 6—Project Timeline and Contacts

12/2009 Initial contact
02/10/10 Conference call with Monitor
03/2010 Initial conference call with the Project Management Team
09/17/10 Mike Mays on history of Medicaid disallowance
09/17/10 Conference call with Jennifer Britton of APA
09/17/10 Conference call with Cynthia Beane--BMS
09/24/10 Mike Mays
09/28/10 Court Monitor and Project Committee Meeting Kick-off Meeting
09/29/10

- 8:00 AM--John Russell, Executive Director, WV Behavioral Health Provider's Association, in the Association Offices
- 10:00 AM--Nancy Fry and Tammi Handley, Legal Aid, in the Office of the Court Monitor
- 11:00 AM--David Sanders, WV Mental Health Consumer's Association, in the Office of the Court Monitor.
- 1:00 PM--Deborah Wilson, Ladonna Stanley, and Jodie Puzio-Bungard, Directors of Social Work in Sharpe and Bateman Hospitals
- 2:00 PM--Michael Mays and Judy Akers, Executive Directors of FMRS and Southern Highlands behavioral health centers
- 4:00 PM--Jennifer Wagner, Esq., Mountain State Justice

09/30/10

- 09:00 AM--Vickie Jones, Commissioner, and Kevin Stalnaker, Deputy Commissioner, Bureau for Behavioral Health and Health Facilities
- 10:00 AM--Regenia Mayne, Esq., West Virginia Advocates
- 11:00 AM--Cindy Beane, Deputy Commissioner, and Cynthia Parsons of the Bureau for Medical Services
- 01:00 PM--Bob Hansen, Executive Director, Prestera Center
- 2:30 PM--Jennifer Britton and staff,
- 4:00 PM--Debrief with David and Sheila

10/2810:

- Mental Health Planning Council
- Listen to MCO presentations
- Interview Consumers, etc.

10/29/10

- 9:30 AM: Tour of St Mary's Hospital in Huntington (distinct part psych facility that provides inpatient treatment for psych patients diverted from Bateman)
- 11:00 AM: Tour of Bateman Hospital (state-operated psychiatric facility). Discussions with staff
- 1:30 PM: Tour of Starlight Behavioral Health Services (one of the few non-comprehensive licensed behavioral health centers that provides services to adult psych

patients)
- 3:00 PM: Tour of Riverpark Hospital (free standing adult and child psych facility in Huntington)
- 5:30 or 6:00 PM: Meet with Karen Yost

11/16/10
- Prestera Center

11/17/10
- Rich Kiley (Appalachian Center)
- Sharpe Hospital—tour and meeting with staff

11/18/10
- Mike Mays (FMRS) and Judy Ackers (SHCMHC)
- Northwood (Mark Games, Deb Mitchell, Rich Stockley, Ed Nolan, Perry Stanley, Tracey Kinder, Nancy Pogacich)

11/29/10
- Robert Williams—United Summit (telephonic)

11/30/10
- Joanne Powell—Westbrook Health (telephonic)

12/01/10
- Robert Mays—Logan-Mingo (telephonic)
- Craig Curtis—Potomac Highlands (telephonic)

12/0210
- Guy Hensley—Seneca Highlands (telephonic)

12/03/10
- Terry Stemple--Healthways (telephonic)
- Paul Macom—East Ridge (telephonic)

12/17/10
- Cheryl Perone—Valley Healthcare (telephonic)

Appendix 7—Summary of Reports on the System of Behavioral Healthcare in WV

As part of this project, CSM reviewed a number of recent reports and system evaluations that have been completed during the last few years. The following represents a brief synopsis of each report and major recommendations they offered. They are listed in chronological order.

"Transforming Behavioral Healthcare in West Virginia" (7/2/2007). Ron Manderscheid, PhD of Constella Group, LLC and Johns Hopkins University—PowerPoint Presentation.

In this report, the findings of a consultation to the VWCBHC Commission and Advisory Board on July 2, 2007 are presented. The report emphasizes the need to reinvent Behavioral Health services by incorporating SAMHSA national vision of System Transformation including services that help consumers with illness management, recovery and the development of resiliency and emphasize consumer and family direction.

The report lists four key strategies for System Transformation"
1. Transforming Financing
2. Transforming Human Resources
3. Adopting Evidence-Based Practices
4. Using IT & Performance Measures

Specific Transformation Issues confronting WV include:

- Consumer and Family Direction
- Integration of Mental Health, Substance Use and Primary Care
- Prevention and Early Intervention
- Quality Improvement
- Accountability
- IT
- Financing Reform

The report's Summary for Future Efforts include:

- Emphasis on Recovery and Consumer/Family Direction are Essential
- Transformation and Quality Improvement are Necessary Partners
- Community Collaboratives will drive Quality Improvement
- A State Strategy is essential to promote Collaboratives and to provide the financial, service, measurement and IT infrastructure necessary for their success

"Proposed Redesign of West Virginia's Behavioral Health Service System—Final Report." (December, 2006). Public Consulting Group. Presented to State of WV Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities.

Public Consulting Group, Inc. (PCG) was contracted by the State of West Virginia Department of Health and Human Resources (DHHR) to facilitate a short- and long-term restructuring of the behavioral health service delivery system. Their December 2006 final Report states that they "reviewed the program, clinical, financial, legal and regulatory components of the current system," met with stakeholders and reviewed state agency reports and documentation, and met with state agency staff to develop their recommendations.

The Final Report lists 23 goals to be achieved to accomplish System Redesign which are summarized below:

1. Establish a group to guide oversee and monitor system redesign that will prioritize regular communication with BHHF
2. Revise and enhance the vision and mission of BHHF to more clearly reflect the values, purpose and philosophy of the Bureau and ensure that stakeholders understand the vision and mission
3. Implement a "Single Point of Entry service brokerage model for accessing behavioral health services that includes an independent service coordination component.
4. Clarify the roles of the various Bureaus within the Dept. of Health and Human Resources (DHHR) including the Bureau of Health and Health Facilities, Bureau of Children and Families, Bureau of Public Health and the Bureau of Medical Services to assure efficient utilization of funds, resources and personnel by providing leadership and policy direction for behavioral health.
5. Develop a new Strategic Plan with goals, strategies and performance outcomes and track goal achievement on an annual basis
6. Enhance BHHF's website the enable consumers to easily access information on behavioral health resources
7. Establish clear definitions for target populations
8. Develop a basic behavioral health service package to be provided throughout the state to all consumers meeting the eligibility criteria. Make services available in all communities with open access to any eligible provider.
9. Maximize clinical and organizational knowledge by facilitating the exchange of information to providers of all supports and services including all licensed and certified clinicians and behavioral health providers.
10. Compel providers to move toward adoption of evidence-based practices. BHHF will promote this through performance-based provider contracts.
11. Improve BHHF utilization and monitoring capabilities through improved data management to insure that outcomes are tracked and used to improve the system.
12. Implement revenue enhancement and cost saving initiatives
13. Implement a fiscal approach that promotes and rewards accountability, programmatic creativity, efficiency and competitiveness.
14. Compel the Office of Health Facilities and the Office of Behavioral Health Services to assure that the system reflects a continuum of services that functions to best meet the needs of target populations.

15. Expand jail diversion strategies such as drug courts, mental health courts, teen courts and treatment compliance orders to divert admissions from forensic beds in state psychiatric hospitals.
16. Provide education and information on the consumer advocacy, grievance, complaint and appeals procedures required of every behavioral health service provider.
17. Expand data collection to include both Medicaid and non-Medicaid eligible populations to improve data of services, improve utilization management and increase quality assurance.
18. Develop an improved plan for staff recruitment, retention and development
19. Maximize service and support available to Medicaid consumers by redesigning existing waivers and writing new waivers to generate new federal revenues for additional service options including options under the Deficit Reduction Act.
20. Review and modify the Health Care Authority's Certificate of Need process to avoid its having a negative impact on consumer choice or a competitive marketplace.
21. Streamline various monitoring and auditing processes to facilitate quality outcomes for consumers without burdensome reporting requirements for providers.
22. Enhance access to services in rural areas by reimbursing providers for telemedicine, electronic medical records and other innovative practices.
23. Review progress on implementation of the Single Point of Entry service brokerage model and communicate the process to stakeholders.

The report presents extensive data on the current pattern of services and funding but does not appear to address how WV can provide the leadership needed to implement the changes required to implement their 23 Goals.

"Integrated Funding Analysis of Mental Health and Substance Use in West Virginia: Joint Meeting of WV Comprehensive Behavioral Health Commission/Advisory Board" by Public Consulting Group (March 13, 2007).

This report was designed to conduct an analysis of the fiscal impact of mental illness and substance use in the State. The following recommendations were proposed:

- WV's mental health system requires additional state and local resources and should leverage these additional resources to maximize federal Medicaid and other funds.
- Collaboration and a significant cultural change among all stakeholders is needed to implement innovative programs associated with proposed Medicaid reforms (i.e. integration of physical health and mental health services).
- An increase in community-based alternative treatment programs would alleviate the burden that is felt across the criminal justice system and other state agencies.
- A more rational funding approach across state agencies where the various programs and the related dollars link up with each other would allow for better statewide coordination and cost efficiencies.
- Enhancements in data collection and reporting capabilities across agencies would allow the state to benchmark and track progress while providing important data for estimating future spending and developing more effective treatment models.

- Re-defining services and establishing consistent terminology across agencies and providers would yield more transparency in the system and lead to improved collaboration among agencies and other providers.
- The State should study alternatives for improving access to services in rural areas with focus on community-based alternatives.
- The State should also conduct an inpatient bed demand study in order to "right size" the present complement of inpatient beds to meet the needs of programs such as Jail Diversion. (pp. 13-15)

"Following the rules: A report on Federal Rules and state actions to cover community mental health services under Medicaid." (2008). Bazelon Center. Retrieved from www.bazelon.org/pdf/followingrules.pdf

This report provides a comparison by state of those community mental health services approved under Medicaid. The comparison addresses a range of clinics and administrative service areas including :

- Crisis Intervention, including: Mobile Crisis Response, Crisis Stabilization, SA Outpatient, SA Intensive Outpatient, SA Ambulatory Detox, Methadone Maintenance, Partial Hospitalization, Day Treatment (MH), and Day Treatment (SA).
    - ❖ Of these services, the review indicates that WV only provides Crisis Intervention and Crisis Stabilization.

- Rehabilitation Services, including: Site-based Rehabilitation, Drop-in Centers, Club Houses, Employment Skills, Services at Job Site, Housing Skills, Education Skills, Recreation-based Services, Socialization, and Natural Supports.
    - ❖ Of these services, the review indicates that WV allows for only Employment Skills and Education Skills.

- Evidenced-Based Practices for Adults, including: Supportive Employment, Supported Housing, Supported Education, Family Psychoeducation, Illness/Disability Self-Management, Integration MH-SA Treatment, and Assertive Community Treatment (ACT).
    - ❖ Of these services, the review indicates that WV only provides ACT.

- Payment Rules are also reviewed, including: Transition Services (one level of care to another), Consultation (Two Professionals Paid), Team Consultation, Collateral Contracts, Telepsychiatry, Telephone Contacts with Client Paid, Provider Time in Transit, Peer Specialists, and Behavioral Aides.
    - ❖ The review indicates that WV only provides Consultation (Two Professionals Paid) and Behavioral Aides.

Synopsis of Current Recommendations for Mental Health and Substance Abuse Services in West Virginia: With a Blueprint for Transformation" (August, 2008)—West Virginia Mental Health Planning Council.

This report focuses on the system of care in WV relative to the President's New Freedom Commission on Mental Health. It noted a number of excellent programs and services across the state, but overall felt there were significant deficits and problems. It made the following recommendations.

- Medicaid reimbursement needs to be re-designed to support effective community-based services.

- Develop and implement, by the beginning of Fiscal Year 2009-2010, a true performance-based contract for Community Behavioral Health Centers.

- Create a workable and implementable policy to achieve integration of physical health care and behavioral health care.

- Develop a plan, in collaboration with the Housing Development Authority, to expand availability of a variety of safe, affordable housing.

- Increase the qualifications for entry-level positions in community-based mental health services.

- Develop a system to provide quicker access to services and enable consumers to obtain services better matched to their needs at the beginning of treatment.

- Develop a West Virginia Behavioral Health Training Institute, in conjunction with two or more universities, to instruct Community Behavioral Health Center staff at all levels in developing and implementing evidence-based practice, practice-based evidence, and innovative programs / services that have been proven to have good outcomes.

- Create a data warehouse to enable rapid assessment and accountability of the community behavioral health system.

- Better utilize technology to assure access to services in rural areas.

- Create an annual process to identify and support with State funds services and programs that have achieved desired outcomes for at least two years, using "demonstration funding" from sources like the Community Mental Health Services Block Grant.

- Create an annual anti-stigma campaign, in collaboration between the Bureau for Behavioral Health Services, providers of behavioral health services, and volunteer organizations.

- Conduct a re-assessment of the crisis response system in the State to determine (a) have any recommendations made to the Bureau for Behavioral Health and Health Facilities been considered / implemented? and (b) are there any changes in the crisis response system?

- Develop and implement a plan to assure cultural competence that includes addressing issues of rurality in the State.

- Expand the availability of school-based mental health services, develop a preferred model / approach to this service, and monitor for fidelity to the model. (pp. 3-4

"Crossroads: Creating a System of Care for Adults with Mental Illness or Co-occurring Disorders." (2009). West Virginia's Comprehensive Community Mental Health Centers.

In 2009 a collaboration of the thirteen Comprehensive Mental Health service providers produced a report, entitled "Crossroads: Creating a System of Care for Adults with Mental Illness or Co-occurring Disorders." The goal of this report was to summarize their collective assessment of the system of care in WV and to make recommendations for its future. The following is a brief outline of the report and recommendations:

- The state is at a "Crossroad" and without appropriate action and resources will likely result in further decay
- Recommend movement toward an evidenced-based approach
- Recommend that the Comprehensives minimally provide five (5) core services including: diagnostic and assessment services, crisis services, linkages with inpatient and residential treatment facilities, treatment services, and support services
- Some of these services would potentially be provided in part by consumer-operated or family support organizations
- Identified need for more accessible Crisis Stabilization Units, mobile crisis, ACT and "modified" ACT teams
- Provide greater access to Day Treatment including programs with multiple levels of care (i.e., "day programming, day supports and consumer-operated Wellness and Recovery Centers" (p. 2, Executive Summary)
- Recommend improved planning and services for those with co-occurring mental illness and substance abuse
- Greater use of Care Coordination and other community-based support services, and
- Increased residential supports including group homes and other residential slots.

"NAMI Grading the States 2006." National Alliance on Mental Illness. Retrieved from http://www.nami.org/Content/NavigationMenu/Grading_the_States/Full_Report/GTS06_final.pdf

Excerpts from NAMI's triennial review and assessment of West Virginia's mental health system of care:

- Overall Grade of "D" with Infrastructure a D-, Information Access a B, Services a D+, and Recovery Supports a D-. Ranked 45 in per capita mental health spending, 49 on per capita income, 43 on total mental health spending, and 8 on suicide rank.[58]

- "In celebrating the exit from the decree, the West Virginia Behavioral Health Providers Association suggested that the pivotal issue of Hartley was "whether or not the state could support these people through alternative funding and support systems like Assertive Community Treatment (ACT) or Medicaid community focused treatment teams." If this measure was the central point, then the state has failed miserably. As of 2005, the state lists only two operational teams for the entire state of West Virginia." (p. 177)

- "West Virginia still approaches behavioral health services without understanding the importance of holistic planning. The state has failed to learn from Hartley, and continues to develop services without adopting a coordinated approach based upon constituent needs and data evaluation. Advocates continue to push for coordinated planning and are advocating legislation to that effect in 2006." (p. 177)

- Challenges included needing to embrace evidence-based practices, greater funding with about 90% already being from Medicaid and the state underfunded Medicaid resulting in losses, minimal access to psychotropic medications, a need for revamping the Medicaid system, improved availability of housing and housing supports. Some positives were openness to consumers/family input and outside advocates, awareness of issues related to mental illness and need for jail diversion programs, and some awareness and addressing of shortages of mental health professionals.

Specific Recommendations Include:

- West Virginia state leaders must challenge local and county officials to operationalize the lessons learned from a 2005 summit on pre-and post-arrest jail diversion.
- West Virginia must expand implementation of evidence-based practices far beyond its currently sparse distribution across the state.
- West Virginia must adopt a coordinated planning approach based upon constituent needs and data evaluation.
- West Virginia must ensure that any newly crafted Medicaid program does not include pay structures that cause those with mental illnesses to choose not to seek treatment or appropriate medications." (p. 179)

"NAMI Grading the States 2009." National Alliance on Mental Illness. Retrieved from http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459

[58] CSM comparison states were graded as follows during the same time period: Texas = C, Nebraska = D, and Iowa = F.

- Overall Grade of "F" with Health Promotion and Measurement a D, Financing and Core Treatment/Recovery Services an F, Consumer and Family Empowerment an F, and Community Integration and Social Inclusion an F.[59]

- "In 2006, West Virginia's mental health care system received a D grade. Three years later, the grade has fallen to an F. An already inadequate system is deteriorating. One reason is the horrendous redesign of its Medicaid program. "(p. 153)

- "Mountain Health Choices is a disaster. It has set the state back in meeting public health needs, financially destabilized providers, and deprived some consumers of needed services in a state that already suffered from uneven access to care and a lack of evidence-based practices." (p. 153)

- Positives: WV MH Consumers association and one mental health court
- Needs:
    - ❖ Redesign Medicaid plan—the right way
    - ❖ Evidence-based practices
    - ❖ Supportive housing and workforce development
    - ❖ Crisis intervention, jail diversion, and reentry programs (p. 153)

- Overall Assessment: "The state is weak in many areas. Services—such as acute and long-term care for individuals with co-occurring disorders—are scarce or non-existent in small towns and rural areas. Involuntary commitments at the two state hospitals continue to increase because of the lack of community treatment services and lack of supported housing. The hospitals are overcrowded, with forensic patients occupying many of the state hospital beds. Some areas have long waiting lists for services. Mountain Health Choices is a disaster. It has set the state back in meeting public health needs, financially destabilized providers, and deprived some consumers of needed services in a state that already suffered from uneven access to care and a lack of evidence-based practices. West Virginia faces many challenges: poverty, the rural nature of the state, and lack of investment in community mental health. Sadly, its leadership example in the face of crisis has been primarily to demonstrate what poor, rural states should *not* do." (p. 153)

"Realizing Our Potential: Transforming West Virginia's Behavioral Health System" (May 21, 2009). Task Force on Behavioral Health Services Preliminary Report.—WV Comprehensive Behavioral Health Commission.

- This report made "six overarching goals that drive the transformation process to an improved comprehensive behavioral health system in West Virginia:

    A. Develop and implement a model of care that supports and incentivizes the integration

[59] All CSM comparison states were graded a "D" during the same time period.

of behavioral health and primary care, improves the availability, coordination and accessibility of behavioral health services, and focuses on prevention and early intervention in communities.

B. Improve the quality of care for consumers by fostering a system that emphasizes continuous improvement, expects accountability for delivering cost-effective and successful outcomes, and encourages the informed use of evidence based practices.
C. Develop coordinated financing strategies for sustainable services in the future behavioral health system that include blended funding streams, formal cooperation between public and private organizations for additional funding, a formalized review process of publicly funded behavioral health services, and true mental health parity.
D. Reduce all stigma associated with behavioral health and its services in West Virginia.
E. Cultivate, train, and retain highly skilled behavioral health care workers and leaders who are empowered to enjoy a professionally rewarding career within a productive and supportive work environment.
F. Use leading, cost-effective technologies to support a comprehensive behavioral health care system in West Virginia. (p. 1)

- To realize the preceding goals, the Task Force of the Commission recommended the following:

  - There were a few participants who strongly believed that recommendations related to increasing resources at state hospitals should not be included in the report because they would not address the Task Force charge of reducing the census in state psychiatric hospitals. However, the majority of members voted to leave them in the report. Within this category, the two prioritization methods highlighted the following two recommendations:
    1. **Increase the pay rates for staff employees at the state psychiatric hospitals**
    2. **Enhance the use of uncompensated care incentives**

  - Increasing resources for hospital alternatives generated significant discussion during the two meetings and, not surprisingly, the number one overall recommendation came from this category. The two recommendations from this category that were significantly higher are listed below:
    1. **Increase the prevalence and support for a variety of group homes – transitional, short-term and long-term**
    2. **Create a crisis intervention system that is accessible and integrated**

  - After hearing from various providers that were members of the Task Force and those who participated in the panel discussions, many members thought that reimbursement of existing services should be enhanced across the entire spectrum of providers (e.g., comprehensives, private, universities). In fact, many of the weighted votes cast by members treated the code categories as equals. Summarizing the information from the two methods coalesced the thoughts of the members into the following two recommendations:
    1. **Enhance reimbursement rates for community services provided under**

the clinic, specialty, rehabilitation and community health center codes
2. **Enhance reimbursement rates for targeted case management**

- In addition to enhancing rates for existing services, the need for reimbursement for additional services not currently covered was also a top priority. The top three recommendations, when considering both prioritization methods, are listed below:
    1. **Provide additional funding for peer supports, supported living and basic living skills**
    2. **Provide additional funding for mental health courts**
    3. **Provide additional funding for care coordination (p. 7)**

Laurie A. Helgoe (6/18/10). "Behavioral Health for the Vulnerable: Can HMOs Deliver?"—For the WV Behavioral Healthcare Providers Association

Overall, this is a rather scathing report on the nature of behavioral healthcare services in WV, and one that suggests quite strongly that the use of HMOs will, in all likelihood, provide fewer services for those most vulnerable due to severe and persistent mental illness and co-occurring conditions. She made the following recommendations:

1. Increase transparency as proposed changes in Medicaid delivery are investigated and discussed, and broaden the discussion to include providers and recipients of care. Reviews have found that states that used an open planning process had smoother transitions, better programs, and encountered less resistance.

2. If integration of primary care and mental health care is the goal, primary care physicians must become true medical homes, as defined by the NCQA. This can only be accomplished if data evaluation and care management are integrated.

3. Use consumer and provider focus groups and pilot studies to assess the effects of these programs before implementing them. The failure of Mountain Health Choices is evidence of what can happen when a new idea is implemented before we know if it's a workable idea.

4. HMOs should adopt West Virginia's state and Medicaid clinic and rehabilitation licensing and credentialing processes rather than having West Virginia adopt the licensing and credentialing processes of HMOs.

5. Get feedback from the perspective of consumers: What would help you choose a plan? What sign-up instructions work best for you? What services help you most?

6. Investigate how systems for electronic data transfer can be used and kept simple. Draw on the accumulated knowledge of providers who have implemented and used these systems.

7. Develop and publish specific outcome measures to evaluate the effectiveness of HMO care for those disabled by mental illness. Unlike medical outcomes, which are more resolution-oriented, these outcome measures would focus more on day-to-day functioning and ability to remain in a less-restrictive setting.

8. Include, in any managed care contract, provisions for the payment of court-ordered services such as court-ordered inpatient or diversionary treatment.

9. Obtain from community behavioral health providers a list all of the services and providers, professional and nonprofessional, needed to provide a strong community support structure for the mentally ill. Evaluate the capacity of the HMOs to support this structure, and address discrepancies in contract negotiations.

10. Protect providers' reimbursement for all current services at the current Medicaid rate for the next year. Providers believe that current services should continue to be reimbursed at least at the same rate, not just during the next year, but also for the foreseeable future.

11. Move slowly, gradually phasing in changes to allow providers and recipients a chance to adapt, ask questions, and "work the bugs out" as new systems are introduced.

12. Redefine "medical necessity" to include behavioral health conditions. Consider, as Iowa did, expanding the definition to include "psychosocial necessity."

13. Reexamine the meaning of "integrated services" in the light of subcontracted services, medical primary care, and utilization of behavioral health services.

14. Require HMOs to pay for medical and behavioral health services when both are scheduled on the same day, and build in assurances that primary care is not assumed to be primarily medical care.

15. The state should publish on its Web site the HEDIS data for the plans. Data from the last three years should be made available by June 30 and then on an ongoing basis as soon as the data are presented to the state.

16. All behavioral health providers, especially those having tele-health capability, should be able to participate, since access to health care providers is limited in a rural state like West Virginia. (pp. 22-24)

Appendix 8—State Cost-Share Sheet (zoom to see details)

Table 26
West Virginia Behavioral Health Facilities
FY 2007 - FY 2009 Revenue and Expense
(Dollars in Thousands)

Behavioral Health Provider	Revenue			Expenses			EROE or Change in Unrestricted Net Assets			Total Margin	Total Margin
	2007	2008	2009	2007	2008	2009	2007	2008	2009	2008	2009
Comprehensive Behavioral Health Centers											
Appalachian Community Health Center	$4,368	$4,539	$4,467	$4,978	$4,860	$4,779	($610)	($321)	($312)	-7.1%	-7.0%
EastRidge Health Systems	7,265	8,113	7,427	7,339	7,915	7,304	(73)	198	123	2.4%	1.7%
FMRS Health Systems	10,908	10,915	10,546	10,258	10,689	10,327	650	226	219	2.1%	2.1%
HealthWays	8,971	9,496	9,660	8,666	9,123	9,323	305	374	337	3.9%	3.5%
Logan-Mingo Area Mental Health	6,788	6,402	6,313	6,815	6,692	6,390	(26)	(289)	(77)	-4.5%	-1.2%
Northwood Health Systems	23,661	24,460	23,515	23,107	24,019	22,630	554	441	885	1.8%	3.8%
Potomac Highlands Guild	5,281	5,613	5,630	5,217	5,414	5,802	64	199	(173)	3.5%	-3.1%
Prestera Center for Mental Health Services	32,123	35,820	36,891	31,097	33,972	36,405	1,026	1,848	486	5.2%	1.3%
Seneca Health Services	17,060	17,659	18,073	16,760	17,313	18,067	300	346	6	2.0%	0.0%
Southern Highlands Community Mental Health Center	10,155	10,415	10,448	10,313	10,663	10,830	(158)	(247)	(381)	-2.4%	-3.6%
United Summit Center	16,118	17,306	17,811	15,288	16,637	17,765	830	669	46	3.9%	0.3%
Valley HealthCare System	12,913	13,877	14,852	13,772	14,744	14,959	(860)	(867)	(107)	-6.2%	-0.7%
Westbrook Health Services	14,434	15,047	15,256	13,947	14,812	15,402	487	234	(146)	1.6%	-1.0%
Total Comprehensives	**$170,045**	**$179,662**	**$180,889**	**$167,557**	**$176,852**	**$179,984**	**$2,488**	**$2,811**	**$905**	**1.6%**	**0.5%**
Other Behavioral Health Providers											
Alldredge Wilderness Journey**	$ 3,862	$2,595	Closed	$ 7,120	$ 5,268	Closed	($ 3,258)	($ 2,672)	closed	-103.0%	
ARC of Harrison County	3,036	3,229	3,541	2,986	3,075	3,325	50	153	216	4.7%	6.1%
ARC of Three Rivers	8,698	9,321	9,622	8,553	9,511	9,764	145	(190)	(142)	-2.0%	-1.5%
Autism Services Center	12,251	12,713	12,229	11,939	12,442	11,873	312	271	356	2.1%	2.9%
Behavioral Health Solutions	130	187	433	55	71	295	75	117	138	62.3%	32.0%
Betsy Broh House	43	43	41	37	47	42	6	(5)	(1)	-10.9%	-1.5%
Board of Child Care	4,356	4,607	4,710	5,713	5,961	6,105	(1,357)	(1,354)	(1,395)	-29.4%	-29.6%
Braley & Thompson	4,513	3,061	3,061	4,966	3,599	3,596	(453)	(538)	(535)	-17.6%	-17.5%
B-U Group Home	1,724	1,772	1,793	1,773	1,796	1,983	(50)	(24)	(190)	-1.3%	-10.6%
Burlington United Methodist Family Services	8,450	9,662	11,807	7,576	8,933	9,769	874	730	2,038	7.6%	17.3%
Charles W. Cammack Children's Center	2,301	1,962	2,518	2,177	2,257	1,987	123	(295)	531	-15.0%	21.1%
Children's Home of Wheeling	5,382	2,901	2,564	3,760	2,937	2,795	1,622	(36)	(231)	-1.2%	-9.0%
Children's Home Society of West Virginia	12,522	11,850	13,966	11,867	11,871	12,383	655	(21)	1,582	-0.2%	11.3%
Community Services	2,903	2,935	2,600	2,940	2,953	2,587	(37)	(17)	13	-0.6%	0.5%
Coordinating Council for Independent Living	19,572	22,113	25,053	18,990	20,959	24,050	582	1,154	1,003	5.2%	4.0%
Council of the Southern Mountains	62	482	652	58	471	657	4	11	(5)	2.3%	-0.8%
Crittenton Services	4,237	4,447	4,636	4,251	4,182	4,369	(14)	265	267	6.0%	5.8%
Daily Companions	1,104	999	1,154	1,113	1,081	1,167	(9)	(82)	(13)	-8.2%	-1.1%
Damous Psychological Services	791	788	955	787	783	893	4	5	62	0.6%	6.5%
Davis-Stuart	5,310	4,741	4,857	4,656	4,658	4,810	654	83	46	1.7%	1.0%
Daymark	1,445	1,552	2,035	1,519	1,656	1,790	(75)	(104)	245	-6.7%	12.1%
Deaf Education and Advocacy Focus of West Virginia	NR	closed	closed	NR	closed	closed	NR	closed	closed		
Developmental Center & Workshop	1,037	987	947	904	878	821	133	110	126	11.1%	13.3%
Elkins Family Counseling Center	428	350	282	420	368	258	8	(19)	24	-5.4%	8.4%
Elkins Mountain School	5,743	5,699	5,803	5,640	5,741	5,682	103	(41)	121	-0.7%	2.1%
Evergreen Behavioral Health Center**	514	closed	closed	551	closed	closed	(37)	closed	closed		
Family Connections	741	736	883	736	754	773	5	(18)	110	-2.4%	12.4%
Family Counseling Connection	821	834	793	780	765	814	41	69	(22)	8.3%	-2.7%
Family Options Providers	1,572	1,399	1,370	1,486	1,411	1,371	86	(12)	(1)	-0.9%	-0.1%
Family Preservation Services of West Virginia	1,196	1,547	1,285	1,116	988	1,046	80	559	239	36.1%	18.6%
Family Service of Marion and Harrison Counties	873	992	1,112	882	980	1,096	(8)	12	16	1.2%	1.4%
Family Service-Upper Ohio Valley	2,262	NA	NA	2,120	NA	NA	143	NA	NA		
Genesis Youth Crisis Center	1,799	1,846	2,084	1,775	1,878	1,954	25	(33)	130	-1.8%	6.2%
Global Access	84	92	69	66	47	43	18	44	26	48.4%	37.9%
Golden Girl	1,570	1,779	1,752	1,610	1,696	1,800	(40)	83	(48)	4.6%	-2.8%
Green Acres Regional Center***	4,642	4,526	NA	4,679	5,718	NA	(37)	(1,192)	NA	-26.3%	
Greenbrier Academy for Girls***	94	989	1,934	101	1,004	1,925	(7)	(15)	9	-1.5%	0.5%
Hampshire County Special Services Center	669	709	759	631	672	729	38	37	30	5.2%	4.0%
Highland Health Center	568	1,185	1,305	598	872	984	(30)	313	321	26.4%	24.6%
Home Base	1,833	2,315	2,829	1,767	2,352	2,868	66	(37)	(38)	-1.6%	-1.4%
Horizons Center for Independent Living	281	410	444	197	275	321	84	135	123	33.0%	27.8%
Integrated Resources	3,634	3,980	4,534	3,721	4,057	4,535	(87)	(77)	–	-1.9%	0.0%
Kanawha Valley Center	11,299	11,679	13,662	10,902	10,867	12,609	396	812	1,053	6.9%	7.7%
Kanawha Valley Senior Services	849	988	199	371	320	446	478	668	(247)	67.6%	-124.5%
Mainstream Services	796	1,231	1,813	715	1,218	1,915	81	13	(103)	1.1%	-5.7%
Martin Behavioral Health	NR	closed	closed	NR	closed	closed	NR	closed	closed		
Mid Valley Health Care	438	4,642	5,945	176	2,489	4,112	262	2,153	1,833	46.4%	30.8%
Monongalia County Youth Services Center	681	745	734	686	722	764	(4)	22	(30)	3.0%	-4.1%
National Youth Advocate Program	2,716	2,625	2,406	2,950	2,558	2,482	(234)	67	(76)	2.6%	-3.1%
Necco	639	780	900	823	913	904	(185)	(132)	(4)	-17.0%	-0.4%
New Hope Residential Services	904	959	913	886	920	916	18	39	(3)	4.1%	-0.4%
New Horizons Therapy Services*	NA	NA	79	NA	NA	29	NA	NA	49		62.7%
New River Ranch	1,240	1,190	1,148	1,140	1,277	1,215	100	(87)	(67)	-7.3%	-5.9%
Olympic Center - Preston	2,509	1,843	1,715	1,851	1,874	1,757	658	(32)	(42)	-1.7%	-2.4%
Open Doors for the Developmentally Challenged	4,111	4,038	4,185	4,021	4,129	4,365	120	(92)	(180)	-2.3%	-4.3%
PACE Training and Evaluation Center	4,857	3,926	4,222	3,892	3,938	4,094	965	(11)	128	-0.3%	3.0%
Potomac Center	7,099	6,786	7,066	7,163	7,503	7,397	(64)	(717)	(331)	-10.6%	-4.7%
Pressley Ridge Schools	15,896	16,030	15,744	15,771	16,042	15,757	126	(12)	(14)	-0.1%	-0.1%
Process Strategies	9,607	10,029	8,605	9,237	9,633	8,833	371	395	(228)	3.9%	-2.7%
Psychological Assessment and Intervention Services	8,343	8,111	7,921	8,335	8,092	7,939	8	19	(17)	0.2%	-0.2%
REM Community Options	46,581	51,634	54,336	46,994	52,911	55,093	(413)	(1,277)	(758)	-2.5%	-1.4%
REM West Virginia	8,850	8,994	9,348	7,782	8,167	8,099	1,068	827	1,249	9.2%	13.4%
RSCR, West Virginia	37,129	39,773	44,061	33,491	34,945	38,722	3,638	4,828	5,340	12.1%	12.1%
Russell Nesbitt Services	4,299	4,013	4,111	3,970	4,182	4,097	329	(169)	14	-4.2%	0.3%
So Others Might Eat (Exodus and Maya Angelou Houses)	1,278	1,273	1,323	1,278	1,273	1,323				0.0%	0.0%
Solutions Positive Behavior Strategies	96	266	1,091	102	269	1,090	(6)	(4)	1	-1.4%	0.1%
St. John's Home for Children	753	792	870	672	735	810	81	56	60	7.1%	6.9%
Starlight Behavioral Health	1,820	3,959	4,637	1,678	3,684	5,132	142	274	(495)	6.9%	-10.7%
Stepping Stone	545	587	577	553	547	558	(8)	40	19	6.9%	3.3%
Stepping Stones	1,159	1,418	1,187	1,093	1,236	1,356	65	183	(169)	12.9%	-14.3%
Stepping Stones Cottages	2,066	2,174	2,173	1,697	1,855	1,838	368	319	335	14.7%	15.4%
Stonebrook	2,288	2,404	2,648	2,085	2,309	2,420	203	95	228	3.9%	8.6%
Sycamore Run	421	643	902	343	632	799	78	11	103	1.8%	11.5%
Tri-County Behavioral Health	NA		76	NA	2	31	NA	(2)	45		59.6%
Try-Again Homes	1,988	2,037	2,041	1,938	1,910	2,050	50	127	(9)	6.2%	-0.4%
VOCA Corporation of West Virginia	33,560	38,048	44,740	28,686	32,096	37,666	4,874	5,953	7,074	15.6%	15.8%
Worthington Center	1,936			2,256			(320)	NR	NR		
Yore Academy*	NA	NA	1,994	NA	NA	1,857	NA	NA	138		6.9%
Youth Academy	1,931	1,944	1,924	1,689	1,937	1,779	242	6	146	0.3%	7.6%
Youth Health Service	2,372	2,030	1,668	2,251	2,109	1,947	121	(78)	(279)	-3.9%	-16.7%
Youth Services System	5,259	5,521	6,298	5,130	5,377	6,427	129	144	(129)	2.6%	-2.0%
Total Others	**$359,395**	**$375,445**	**$399,676**	**$345,220**	**$363,638**	**$379,889**	**$14,175**	**$11,806**	**$19,787**	**3.1%**	**5.0%**
Total Comprehensives and Other	**$529,440**	**$555,107**	**$580,565**	**$512,778**	**$540,490**	**$559,873**	**$16,662**	**$14,617**	**$20,692**	**2.6%**	**3.6%**
Methadone Treatment Centers											
Beckley Treatment Center	$3,635	$3,876	$4,018	$2,396	$2,342	$2,454	$1,239	$1,533	$1,564	39.6%	38.9%
Charleston Treatment Center	3,453	3,074	3,267	2,515	2,081	1,982	938	993	1,285	32.3%	39.3%
Clarksburg Treatment Center	1,273	1,495	1,438	1,066	1,138	1,144	207	357	294	23.9%	20.4%
Huntington Treatment Center	5,065	4,575	4,631	3,226	2,722	2,566	1,839	1,854	2,065	40.5%	44.6%
Martinsburg Institute	1,357	1,399	1,479	975	1,072	1,155	383	327	324	23.3%	21.9%
Parkersburg Treatment Center	1,131	1,098	1,344	936	1,010	924	195	88	420	8.0%	31.3%
Valley Alliance Treatment Services	NA	NR	635	NA	NR	564	NA	NR	71		11.1%
Wheeling Treatment Center	1,129	1,199	1,267	1,026	1,003	951	103	196	316	16.3%	24.9%
Williamson Treatment Center	3,509	3,572	3,729	2,312	2,271	2,185	1,197	1,301	1,544	36.4%	41.4%
Total	**$20,552**	**$20,288**	**$21,807**	**$14,452**	**$13,640**	**$13,924**	**$6,101**	**$6,648**	**$7,883**	**32.8%**	**36.2%**
Grand Total All Providers	**$549,992**	**$575,396**	**$602,373**	**$527,229**	**$554,130**	**$573,797**	**$22,763**	**$21,266**	**$28,576**	**3.7%**	**4.7%**

Source: Data from financial statements submitted by facilities.
EROE: Excess (Deficit) Revenue Over Expenses
NA: Not Applicable; NR: Not Reported
Note: Unrealized gains and/or losses on investments are excluded from data.
Restatements are included in FY 2007 and FY 2008 totals.
– The value is too small to register in thousands.
Facilities added or delicensed as providers:
*New Horizons Therapy Services initially licensed August 2009 , 5 months of data provided.
*Yore Academy was incorporated in June 2008 and was initially licensed January 7, 2009.
Facilities closed:
**Alldredge Wilderness Journey closed December 2008.
**Evergreen Behavioral Health closed in November 2008
Acquistions and Name Changes:
***Green Acres Regional Center's behavioral health license was acquired by ResCare in August 2008 (FY 2009).
***Greenbrier Academy for Girls formerly known as The Greenbrier Academy was operated by two companies during FY 2009: (The Greenbrier Academy Charitable Trust (January 1 - November 30), and Relational Management Sevices, LLC (beginning December 1).

Appendix 9—Project Management Team Membership

- David Sudbeck, Court Monitor
- Sheila Kelly, Special Assistant to the Court Monitor
- Vicki Parlier Jones; Commissioner, Bureau for Behavioral Health and Health Facilities
- Cynthia Beane; Director, Policy Administrative Services BMS
- Jennifer Wagner; Mountain State Justice
- John Russell; Executive Director, WV Behavioral Health Provider's Association
- David Sanders; Consumer Affairs Executive Assistant, WV Mental Health Consumer's Association
- Bill Albert; Director, Legal Aid of WV Behavioral Health Advocacy Program